LIFE SPECIALTY SOLUTIONS

ACTEMRA
(tocilizumab)

PATIENT INFORMATION

PATIENT NAME: PHONE #:

ADDRESS: CITY, STATE, ZIP:

DATE OF BIRTH: EMAIL:

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. H&P 3. Patient Demographics 4. Baseline LFTs and Lipid Panel 5. Medication List

6. TB Test	DATE:	RESULTS:
7. Absolute Neutrophil Count	DATE:	RESULTS:
8. Platelet Count	DATE:	RESULTS:

PRIMARY DIAGNOSIS

☐ M31.6 Other giant cell arteritis
☐ M06.00 Rheumatoid arthritis without rheumatoid factor, unspecified site
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M06.00 Rheumatoid arthritis without rheumatoid factor, multiple site
☐ Other

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LABS

Please list any labs to be drawn by the infusion clinic:

☐ Absolute Neutrophil Count at month 2 and every 3 months thereafter
☐ Platelet Count at month 2 and every 3 months thereafter
☐ LFTs Count at month 2 and every 3 months thereafter

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Actemra
☐ Provider Prescribed:

PRIMARY MEDICATION ORDER

Actemra IV

☐ 4mg/kg ☐ 6mg/kg
☐ Fixed dose ☐ 8mg/kg
☐ Other:

Frequency

☐ Every 4 weeks ☐ Other
FIRST DOSE?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted.

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC
☑ Flush device per Real Medix - Real infusions protocol (See www.realinfusions.com for detailed policy)
☐ Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real infusions protocol (See www.realinfusions.com for detailed policy)
☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: PHONE:

OFFICE CONTACT: FAX:

ADDRESS: EMAIL:

CITY, STATE, ZIP: NPI AND LICENSE:

✖

PROVIDER SIGNATURE DATE

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