Infusion ASSOCIATES

Phone: 616-954-0600 Fax: 616-954-1675

Actemra IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

In the past year, what medications for the above diagnosis has the patient tried and failed?
☐ N/A continuation of treatment

Drug	Dose	Dates of use

Does the patient have moderate to severe heart failure? ☐ No ☐ Yes
Will the patient be receiving other biologic therapy in combination with Actemra? ☐ No ☐ Yes
*If yes to above, please provide rational for use:*_____

TB verification ***(circle one):*** **TB skin test** **TB spot/Quantiferon blood test** **Chest X-RAY**

Result Date: _____/_____/_____ Result ***(circle one):*** **Positive** **Negative**

Labs to be collected: ☐ CMP ☐ CBC w/o diff ☐ CBC w/diff ☐ CBC w/man diff ☐ CRP ☐ Other: _____

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ Other:_____

Pre- Medications: (usually not indicated):_____

Actemra (tocilizumab) IV :

Maximum dose is 800 mg

☐ 4mg/kg ☐ 8mg/kg ☐ Other: _____

Frequency: ☐ q2wks ☐ q 4wks ☐ Other:_____

Rx Expiration Date: _____/_____/_____

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____