



Phone: (833) 394-0600 Fax: (833) 996-4888

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?

Drug	Dose	Dates of use

Will the patient be receiving other biologic therapy in combination with Actemra? No Yes

If yes to above, please provide rationale 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: BMP CMP CBC w/o diff CBC w/diff CRP ESR Hepatic panel _____

Lab Frequency: EVERY infusion Every OTHER infusion Other: _____

Actemra (tocilizumab) IV

Maximum dose is 800 mg

4mg/kg 6mg/kg 8mg/kg 10mg/kg 12mg/kg _____ mg

Frequency: q2wks q 4wks q _____ wks

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____ Office Fax Number: _____

Contact Name: _____ Contact Phone Number: _____

New referring providers, how did you hear about us? Web Search Pharma Rep Drug Locator Patient
 Word of Mouth IA Clinical Liaison IA Website Facebook Instagram Other: _____