Actemra Order
(Tocilizumab)

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ___/___/___ Treatment Location: _____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to the Diagnosis ☐ Current Medications

PATIENT INFORMATION

Patient Name: _____

DOB: ___/___/___

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ___/___/___

Phone: (___) ___-____ Fax: (___) ___-____

Office Address: _____

Contact Person: _____

TB TEST / CHEST X-RAY

Result: _____ Test Date: ___/___/___ ☐ Copy Attached

PRE-MEDICATIONS: (USUALLY NOT INDICATED)

Benadryl:	☐ PO	☐ IV	☐ 25mg	☐ 50mg	☐ Pre-med	☐ PRN
Acetaminophen:	☐ PO		☐ 650mg		☐ Pre-med	☐ PRN

ACTEMRA (TOCILIZUMAB) IV DOSAGE

Maximum Dose is 800mg

☐ 4 mg/kg ☐ 8 mg/kg Every ☐ 4 weeks or ☐ 2 weeks Total dose: _____ mg

Start Date of Infusion: ___/___/___