

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
Primary Language: _____ Allergies: _____
Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code (PROVIDE COMPLETE CODE)

M05. _____ Rheumatoid Arthritis, w/ Rheumatoid Factor
M06. _____ Rheumatoid Arthritis, w/o Rheumatoid Factor
M31.5 Giant Cell Arthritis
Other: _____

Prescribing information

- Dosing exceeding 800 mg is not recommended in RA patients.
- Dosing should not be administered less than every 28 days.

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

LAB RESULTS: Negative TB within 12 months. CBC with diff, Platelets, AST, ALT, and Lipid panel within 60 days.

PRESCRIPTION

ACTEMRA (tocilizumab)

Infuse in 100 mL of 0.9% Sodium Chloride over at least 1 hour

Loading Dose (SELECT ONE)

IV: Infuse 4 mg/kg
IV: Infuse _____ mg/kg

Maintenance Dose (SELECT ONE)

IV: Infuse 4 mg/kg every 4 weeks for one year
IV: Infuse 8 mg/kg every 4 weeks for one year

Patient Weight: _____ lbs or _____ kg

Post Treatment Observations: The patient is observed for 30 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

Lab Orders+

Required: Negative TB
CBC with diff, Platelets, AST, and ALT at 2nd infusion, then every 12 weeks
Lipid Panel, at 2nd infusion, then every six months
+ Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____
Date: _____ NPI #: _____ Specialty: _____
Supervising Physician: _____ (If Applicable)
Address: _____ City: _____ State: _____ Zip: _____
Contact Name: _____ Phone: _____ Fax: _____ Email: _____