PEDIATRIC: Actemra Order Form

(tocilizumab) See separate adult form

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ M08.2 _____ Juvenile Rheumatoid Arthritis w/Systemic Onset

☐ M08.3 Juvenile Rheumatoid Polyarthritis (Seronegative)

Other: _____

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)

Weight < 30 kg infuse in 50 mL of 0.9% Sodium Chloride
Weight ≥ 30 kg infuse in 100 mL of 0.9% Sodium Chloride

☐ **Cytokine Release Syndrome**
Every 2 weeks (no < 14 days) for one year

IV: (wt < 30 kg): Infuse 12 mg/kg
IV: (wt ≥ 30 kg): Infuse 8 mg/kg

☐ **Polyarticular Juvenile Idiopathic Arthritis**
Every 4 weeks (no < 28 days) for one year

IV: (wt < 30 kg): Infuse 10 mg/kg
IV: (wt ≥ 30 kg): Infuse 8 mg/kg

☐ **Systemic Juvenile Idiopathic Arthritis**
Every 2 weeks (no < 14 days) for one year

IV: (wt < 30 kg): Infuse 12 mg/kg
IV: (wt ≥ 30 kg): Infuse 8 mg/kg

Lab Orders+

Required: Negative TB
CBC with diff, Platelets, AST, and ALT, at 2nd infusion, then every 8 weeks for Polyarticular JIA and every 4 weeks for Systemic JIA.
Lipid Panel, at 2nd infusion, then every six months

+ Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider

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:

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____