medix infusion

Actemra Order Form

(tocilizumab) See Separate Pediatric 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)

☐ 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

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

Patient Weight: _____ lbs **or** _____ kg

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**
If yes, please note therapy and last dose: _____

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

Comments:

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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