Pediatric: Actemra® Order Form
(tocilizumab)

FAX TO: 972.499.9210

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F

Ht: _____ Wt: _____☐ lbs ☐ kg Primary Language: _____

Allergies: _____Patient Preferred Location: _____

Diagnosis

Primary ICD 10 Code (Required)

☐ M08.2 Juvenile Rheumatoid Arthritis, w/Systemic Onset
☐ M08.3 Juvenile Rheumatoid Polyarthritis (Seronegative)
Other: _____
☐ Other ICD 10 Code: _____
Description _____

Patient Status

☐ New to therapy
☐ Continuing therapy (date of last dose _____)

Medication Order

Pre-Medications

_____

ACTEMRA (tocilizumab)

☐ **Cytokine Release Syndrome**
One (1) dose per year
(wt < 30 kg): 12 mg/kg IV
(wt ≥ 30 kg): 8 mg/kg IV

☐ **Polyarticular Junvenile Idiopathic Arthritis**
Every 4 weeks (no < 28 days) for one year
(wt < 30 kg): 10 mg/kg IV
(wt ≥ 30 kg): 8 mg/kg IV

☐ **System Juvenile Idiopathic Arthritis**
Every 2 weeks (no < 14 days) for one year
(wt < 30 kg): 12 mg/kg IV
(wt ≥ 30 kg): 8 mg/kg IV

Lab Orders (Required)

- Negative TB
- CBC w/diff, platelets, AST, and ALT at second infusion; then every 8 weeks for Polyarticular JA and every 4 weeks for Systemic JIA
- Lipid panel at second infusion, then every 6 months

Lab Orders+
Requested Add'l Lab Orders:
_____
_____

Lab Frequency: _____every _____weeks

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

Required Clinical Documentation

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Lab Orders: Negative TB test within 12 months of therapy initiation; CBC w/diff, Platelets, AST, ALT, and lipid panel within 60 days

Medix Infusion will collect all necessary labs if not included in referral documents

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

Referring Provider Information

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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