NORTH TEXAS INFUSION CENTERS

Actemra® (tocilizumab) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)
3. TB screening and Hepatitis B vaccine or testing documentation

_____ _____
Patient Name **DOB**

_____ _____ _____
Weight **Allergies** **Patient Phone**

Diagnosis (include ICD10 codes)
☐ Rheumatoid Arthritis _____
☐ Other (ICD-10 Code):_____

Prescription Orders: Actemra® (tocilizumab) - maximum recommended dose=800mg.

☐ Directions: _____ mg/kg every 4 weeks. Infuse over 1 (one) hour.
Or as directed by Prescribing Physician (Specify)_____

Pre-Medications:
☐ Acetaminophen 650mg PO ☐ Benadryl 25mg IVP ☐ Solu-Medrol 40mg IVP
☐ Other _____

Standing Lab Orders: ☐ CMP ☐ CBC ☐ ESR ☐ CRP ☐ Other:_____every infusion

Refills: ☐ 12 months or ☐_____infusions

_____
Physician Name **Phone** **Fax**

_____
Physician's signature **Date**

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com