ACTEMRA

(tocilizumab including biosimilars Tyenne)

FAX to + 1 208.963.3245 or Email to intake@infusionspecialists.org To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:________________lbs or ____________kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Demographics • Baseline LFTs and Lipid Panel • Medication List

• TB Test	Date: ____________________	Results: ____________________
• Absolute Neutrophil Count	Date: ____________________	Results: ____________________
• Platelet Count	Date: ____________________	Results: ____________________

PRIMARY DIAGNOSIS

☐ M31.6 Other giant cell arteritis
☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M06.00 Rheumatoid arthritis without rheumatoid factor, unspecified site
☐ Other: ____________________

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Tocilizumab
☐ Provider Prescribed: ____________________

PRIMARY MEDICATION ORDER

·Actemra or biosimilar (Tyenne, Tofidence) may be used according to payor guidelines
·To prohibit auto-substitution, please indicate specific brand required ____________________
☐ Tocilizumab 4mg/kg (_________mg) IV every 4 weeks
☐ Tocilizumab 6mg/kg (_________mg) IV every 4 weeks
☐ Tocilizumab 8mg/kg (_________mg) IV every 4 weeks
☐ Other: ____________________

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: ____________________

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

______________________________ ______________________________
Provider Signature Date