

Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226



Prince George
2025B Waterside Rd
Prince George, VA 23875

Physician Order - Actrema (tocilizumab)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose/Frequency Change	<input type="checkbox"/> Order Renewal

Location Preference (optional)	
<input type="checkbox"/> Richmond	<input type="checkbox"/> Prince George

** If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access **

DIAGNOSIS AND ICD 1-0 CODE	
<input type="checkbox"/> Rheumatoid Arthritis	M06.9
<input type="checkbox"/> Ankylosing Spondylitis	M45.9
<input type="checkbox"/> Arthropathic Psoriasis	L40.50
<input type="checkbox"/> Juvenile Rheumatoid Arthritis	M08.00
<input type="checkbox"/> Other: _____	ICD10 _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress Notes
<input type="checkbox"/> Patient Demographics AND Insurance Information	<input type="checkbox"/> Labs and Tests Supporting Primary Dx
<input type="checkbox"/> Hepatitis B Test Results: HBsAg	
<input type="checkbox"/> QuantiFERON Gold TB Test Results	
<input type="checkbox"/> Patient currently receiving same therapy at _____	Last dose: _____
List Tried & Failed Therapies, including duration of treatment	
1)	
2)	
3)	

MEDICATION ORDERS**		
Dosing	<input type="checkbox"/> Actrema 4mg/kg infuse IV over 1 hour every 4 weeks	
	<input type="checkbox"/> Actrema 8mg/kg infuse IV over 1 hour every 4 weeks	
	<input type="checkbox"/> Actrema ____ mg/kg infuse IV over 1 hour every 4 weeks	
Patient Weight = _____ kg	Patient Height = ____ ft ____ in	
Duration: <input type="checkbox"/> x 6 months	<input type="checkbox"/> x 1 year	<input type="checkbox"/> doses _____

**Patient weight is required for all weight based therapies - please indicate weight in kilograms.

PREMEDICATIONS	
<input type="checkbox"/> Acetaminophen 650mg PO prior to Actrema infusion	
<input type="checkbox"/> Diphenhydramine 25mg PO prior to Actrema infusion	
<input type="checkbox"/> Methylprednisolone 40mg slow IVP	
<input type="checkbox"/> Other:	

Please note: if an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:	Date:	

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com

Fax completed form and ALL documentation to 804-554-5848

All information contained in this form is strictly confidential and will become part of the patient's record.