ACTEMRA
(tocilizumab)

FLEXCARE INFUSION CENTERS

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: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____
☐ Absolute Neutrophil Count at month 2 and every 3 months thereafter
☐ Platelet Count at month 2 and every 3 months thereafter
☐ LFTs Count at month 2 and every 3 months thereafter

PRE-MEDICATIONS

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

PRIMARY MEDICATION ORDER

- Actemra or biosimilar (Avtozma, 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 (maximum dose 800mg)
☐ Tocilizumab 6mg/kg (_____mg) IV every 4 weeks (maximum dose 800mg)
☐ Tocilizumab 8mg/kg (_____mg) IV every 4 weeks (maximum dose 800mg)
☐ Other: _____

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

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com 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 FlexCare Infusion Centers' protocol (See flexcareinfusion.com 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 _____

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals