

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

Patient Demographics Insurance card Progress Notes supporting DX TB status results Hepatitis B status results

PATIENT

Full Name: _____ DOB: _____
 Mobile Phone: _____ Weight: lbs kg
 Allergies: _____ NKDA
Patient status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

Rheumatoid Arthritis M05. _____ Systemic Sclerosis-Associated Interstitial Lung Disease M31.5
 Giant Cell Arteritis M31. _____ Juvenile rheumatoid arthritis M08. _____
 Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____
 Practice Name: _____ Referral Coordinator Name: _____
 Practice Address: _____
 Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

Acetaminophen (Tylenol) PO 500 mg 650 mg 1000 mg
 Diphenhydramine (Benadryl) PO IV 25 mg 50 mg
 Methylprednisolone (Solu-Medrol) IV 40 mg 125 mg
 Cetirizine (Zyrtec) 10 mg PO
 Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
<input type="checkbox"/> Actemra (Tocilizumab), IV	<input type="checkbox"/> 4 mg/kg <input type="checkbox"/> 8 mg/kg	<input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 4 weeks
<input type="checkbox"/> Tocilizumab Biosimilar, IV: <input type="checkbox"/> Tofidence <input type="checkbox"/> Tyenne <input type="checkbox"/> Avtozma	<input type="checkbox"/> 10 mg/kg <input type="checkbox"/> 12 mg/kg	
<input type="checkbox"/> Actemra (Tocilizumab), Subcutaneous Injection	<input type="checkbox"/> 162 mg	<input type="checkbox"/> Every Week <input type="checkbox"/> Every 2 Weeks
<input type="checkbox"/> Tocilizumab Biosimilar, Subcutaneous Injection <input type="checkbox"/> Tyenne <input type="checkbox"/> Avtozma		
<input type="checkbox"/> Other: _____		

Refills Zero 12 months _____ Order valid for 1 year unless otherwise stated. _____
 Infuse over 60 minutes.
 Flush with 0.9% sodium chloride at infusion completion.
 Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

CBC at each dose every _____
 CMP at each dose every _____
 CRP at each dose every _____
 Other: _____ at each dose every _____

SPECIAL INSTRUCTIONS

Provider Signature _____ Date _____