Provider Order Form

ACTEMRA (TOCILUZUMAB)



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 Giant Cell Arteritis M31 Other:	☐ Systemic Sclerosis-Associated Interstitial Lung Disease M31.5 ☐ Juvenile rheumatoid arthritis M08.
PROVIDER	
Provider Name:	Provider NPI:
Practice Name:	Referral Coordinator Name:
Practice Address:	
Phone: Fax:	Email:
PRE-MEDICATION	
Acetaminophen (Tylenol) PO	
THERAPY ADMINISTRATION	
Medication Dose □ Actemra (Tociluzumab), IV □ 4 mg/l □ 8 mg/l □ 10 mg/l □ 12 mg/l □ 12 mg/l	kg ☐ Every 4 weeks /kg
☐ Actemra (Tociluzumab), Subcutaneous Injection ☐ 162 mg	Every Week ☐ Every 2 Weeks
□ 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 □ CMP □ at each dose □ CRP □ at each dose □ Other □ □ at each dose	every
SPECIAL INSTRUCTIONS	
PLEASE ATTACH THE FOLLOWING SO WE CAN MOST	T EFFICIENTLY PROCESS THE PATIENT'S ORDER
	s supporting DX
Provider Signature	Date
Phone: (734) 203-0176	Fax: (888) 373-5528 Email: referral@untivhealth.com