Site of Care

☐ Home Infusion
☐ Infusion Center
☐ Doctor's Office

Fax Referral to (855) 644-3687 or Email: Referrals@sandshealth.com

ACTEMRA (TOCILUZUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Mobile Number: _____

Patient Weight: _____ Patient Height:_____ Allergies:_____

Other Medications: _____

DIAGNOSIS (Provider must specify)

☐ Rheumatoid Arthritis, ICD10: _____

☐ Giant Cell Arteritis, ICD10: _____

☐ Other: _____

PRE-MEDICATION (Not typically indicated)

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Benadryl 25mg PO ☐ Methylprednisolone (Solu-Medrol) _____mg IVP

☐ Other:_____ Dose:_____ Route: _____

☐ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Actemra	☐ 4 mg/kg ☐ 8 mg/kg ☐ Other: _____	☐ IV	☐ Every 2 weeks ☐ Every 4 weeks ☐ Every _____weeks

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Provider Name: _____ NPI: _____ Contact: _____

Email:_____ Phone: _____ Fax: _____

Signature: _____ Date: _____

Prior to treatment – ensure the following information is complete and attached with referral:

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

Order valid for 1 year from date of signature unless otherwise specified here: