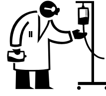

Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

ACTEMRA IV Infusion ORDERS (Tocilizumab)

******Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: ____ **DOB**: _____/_____/_____

Allergies: ___________________________ **Patient Weight:** _________lbs / kg **Height:**_________

Diagnosis:____

DX CODES: ***ICD-10*** : _____________________, _____________________, ____________________

TB verification ***(circle one):*** **TB skin test** **TB spot/Quantiferon blood test** **Chest X-RAY**
☐ **COPY ATTACHED**

Result Date: ________/_______/__________ Result ***(circle one):*** **Positive** **Negative**

Is patient currently on any of these medications: Coumadin/Warfarin or Statins: ☐ No ☐ Yes

LABS to be drawn:
☐ CBC
☐ Liver Function Tests:
☐ Other:_____________

Lab Frequency:
☐ Prior to Actemra infusions
☐ Other:________________

Pre- Medications: (usually not indicated):______________________________________

Start Date of Infusion: _____/_____/_____ **Actemra Infusion #** ___________

Actemra IV Dosage:

Maximum dose is 800 mg

☐ **4mg/kg** ☐ **8mg/kg** ☐ **Other: ____________**

Rx Expiration Date: _____/_____/_____
RX: ACTEMRA DOSING SCHEDULE
EVERY 4wks______ or 2wks_______

INFUSE ACTEMRA OVER 60 MINUTES @100ML/HR

Printed Provider's Name: ____

Provider Signature: ____

Office Phone Number: ______________________Office Fax Number: ________________________________