

**Patient Information**

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
Last infusion date (if applicable):		_____	
Is the patient pregnant, planning a pregnancy or nursing:		Yes	No
Does the patient need interpreter services:		Yes	No

**Provider Information**

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip:

**ICD-10 CODE**

M06.9 Rheumatoid arthritis	M08.40 Polyarticular juvenile idiopathic arthritis
M31.6 Giant Cell arteritis	D89.839 Cytokine release syndrome, grade unspecified
M34.81 Systemic sclerosis associated interstitial lung disease	Other: _____

**Medication Order**

<b>Actemra (tocilizumab) IV INFUSION</b>	<b>Dose:</b>	4mg/kg IV	6mg/kg IV	8mg/kg IV	10mg/kg IV	12mg/kg IV	
	Other: _____mg/kg IV	round up to the nearest whole vial	give exact dose				
	<b>Frequency:</b>	every 2 weeks	every 4 weeks	Other: _____			
<b>Actemra (tocilizumab) SC INJECTION</b>	<b>Dose:</b>	162mg SC	<b>Frequency:</b>	every week	every 2 weeks	every 3 weeks	Other: _____

**Documentation Required (Note: Send all labs, must include specific labs listed here)**

Labs (Need Negative TB)	Insurance Card (front and back)	Current Medications	History/Progress Notes
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**Pre-Medication Order**

<b>acetaminophen</b> (Tylenol)	500mg	650mg	1000mg PO	<b>diphenhydramine</b> (Benadryl)	25mg	50mg /	PO	IV
<b>cetirizine</b> (Zyrtec)	10mg PO			<b>methylprednisolone</b> (Solu-Medrol)	40mg IV	125mg IV		
<b>loratadine</b> (Claritin)	10mg PO			<b>hydrocortisone</b> (Solu-Cortef)	100mg IV			
Other: _____								
Dose: _____			Route: _____			Frequency: _____		

**Special Instructions (Prior therapy, treatment dates, and reasons for d/c)**

<b>Provider Name</b>	<b>Provider Signature</b>	<b>Date</b>
Order Expiration Date (mm/dd/yy): _____ (if not indicated order will expire one year from date signature) Check here if this is a stat order		

**Patient Information**

Patient Name:	DOB:	Sex:	M	F	Fasting:	Y	N
Patient Home Phone:	Patient Cell Phone:						
Emergency/Alternate Contact Name:	Emergency/Alternate Contact Phone:						

**Lab Test (Please circle or write in ICD-10)**

ALT R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	HIV VIRAL LOAD Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20
AST R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgE J45.4, J45.3, L50.9, J45.40, J45.50
HEPATIC FUNCTION PANEL R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgG G35, G36.0
BASIC METABOLIC PANEL I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9	IMMUNOGLOBULIN QUANT IgG, IgM, IgA G35, G36.0
CALCIUM M81.0, M81.8	IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE G35, G36.0
CBC (INCLUDES DIFF/PLT) I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1	IRON, TIBC, FER PNL D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
CBC (H/H, RBC, WBC, PLT)s I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1	LIPID PANEL Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2
COMP METABOLIC PANEL I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9	MAGNESIUM I10, Z79.899, R25.2, E83.42, Z00.00
CREATININE M81.0, M81.8, G35	PSA R97.20, C61, N40.1, Z12.5, N40.0
C-REACTIVE PROTEIN (CRP) R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50	PROTHROMBIN TIME-INR Z79.01, I48.91, I48.0, Z51.81
FERRITIN D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9	TRANSFERRIN SATURATION D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
G6PD M1A.9XX0, M1A.9XX1	QUANTIFERON TB GOLD Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90
GROWTH HORMONE E22, C7A.1, E34	TSH E03.9, I10, E03.8, R53.83, E06.3, E05.00
HBSAG CONFIRMATION Z11.3, Z36.9, Z20.2, Z11.59, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	URIC ACID M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1
HEMOGLOBIN & HEMATOCRIT D50.9, D64.9, D50.0, D63.1, N18.9	VIT B12/FOLIC ACID M89.49, E53.8, R53.83, F41.8, F41.9, E05.00
HEMOGLOBIN A1C E11.9, E11.65, R73.01, Z00.00, I10	VIT D 25- HYDROX E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8
HEP B SURF AG Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	Miscellaneous Labs Not Listed (Write In)
HIV 4TH GEN Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20	
HIV 1/2 AB DIFF Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20	

**Frequency**

Prior to each dose	Yearly	Other: Please Specify Below
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	

Provider Name

Provider Signature

Date

Provider Phone