



MEDICATION ORDERS

ACTEMRA (TOCILIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCE (Optional)
Preferred Location: <input type="checkbox"/> Montgomery <input type="checkbox"/> Prattville

DIAGNOSIS AND ICD 10 CODE
<input type="checkbox"/> Rheumatoid Arthritis ICD 10 Code: M06.9 <input type="checkbox"/> Other: ICD 10 Code: _____

REQUIRED DOCUMENTATION/TESTING	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> TB Test Results	<input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Labs and Tests supporting primary diagnosis
List Tried & Failed Therapies, including duration of treatment:	
1)	
2)	
3)	

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Rheumatoid Arthritis Dosing	<input type="checkbox"/> Actemra 4mg/kg IV every 4 weeks <input type="checkbox"/> Actemra 8mg/kg IV every 4 weeks <input type="checkbox"/> Actemra _____ mg IV every 4 weeks Please note that doses >800mg for RA are not recommended.
Refills: <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> _____ doses	
<ul style="list-style-type: none"> New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines. Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication. 	

PREMEDICATIONS
<input checked="" type="checkbox"/> Acetaminophen 1000mg PO, 30-60 minutes prior to Actemra infusion <input checked="" type="checkbox"/> Diphenhydramine 50mg IV, 30 minutes prior to Actemra infusion <input checked="" type="checkbox"/> Famotidine 20mg IV, 30 minutes prior to Actemra infusion <input checked="" type="checkbox"/> Methylprednisolone 125mg IV 30 minutes prior to Actemra infusion

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
Physician Signature:	Date:		

Contact us with questions at: **Montgomery (334) 273-7000 or Prattville (334) 351-1000**

Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207

All information contained in this form is strictly confidential and will become part of the patient's medical record.