REVITALIZE
INFUSION CENTER

Actemra®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

- ☐ Rheumatoid Arthritis with Rheumatoid Factor — ICD-10 Code: M05.1____
- ☐ Rheumatoid Arthritis without Rheumatoid Factor — ICD-10 Code: M05.2____
- ☐ Giant Cell Arteritis — ICD-10 Code: M31.6____
- ☐ Other_____ — ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
- Required Information:
  - TB screening results
  - Hepatitis B virus screening
  - Recent labs (including CBC with Diff, LFTs, Platelets, & Lipid Panel)

Height: _____

Weight: _____

Actemra (tocilizumab) Orders:

☐ **Initial Dose:** Administer 4 mg/kg IV

☐ **Subsequent Dose:**

☐ 4 mg/kg IV every 4 weeks for 12 months

☐ 8 mg/kg IV every 4 weeks (**Dose not to exceed 800mg**) for 12 months

Pre-Medication Orders:

☐ Acetaminophen 650 mg PO ☐ Cetirizine 10 mg PO ☐ Diphenhydramine 50 mg IV

☐ Loratadine 10 mg PO ☐ Other: _____

Lab Orders:

☐ CBC with Diff, Platelets, LFTs prior to second infusion then every 12 weeks

☐ Lipid Panel prior to second infusion then every 6 months.

☐ Other: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus