PREMIER INFUSION CENTER

Actemra (Tocilizumab) Infusion Order Form

Send Orders by Fax: 📠 405-442-7223 or Email: 📧 orders@premierinfusioncenter.com

🔹 Patient Information

- Full Name: _____ DOB: ____ / ____ / _____
- Phone: _____ Email: _____
- Address: _____ Weight: _____ lb/kg
- Allergies: ☐ NKDA ☐ _____
- Treatment Status: ☐ New ☐ Continued Last Treatment: ____ / ____ / ____

🔹 Diagnosis (ICD-10 Selection)

☐ **M05.79** – Rheumatoid arthritis with rheumatoid factor, involving multiple sites but without organ or systemic involvement
☐ **M06.9** – Rheumatoid arthritis, unspecified — used when clinical presentation does not specify type
☐ **M31.6** – Other giant cell arteritis — including temporal arteritis with atypical features or extracranial involvement
☐ **M34.81** – Systemic sclerosis with lung involvement — includes scleroderma affecting pulmonary function
☐ **Other:** _____ **ICD-10 Code:** _____

🔹 Infusion Order

- Dose: ☐ 4 mg/kg ☐ 6 mg/kg (GCA only) ☐ 8 mg/kg (Max 800 mg)
- Frequency: ☐ q2w ☐ q4w Duration: ≥60 mins
- Refills: _____

🔹 Line Use & Access

☐ Start PIV ☐ Access CVC ☐ Use PICC Line

☑ Flush per Premier Infusion Center protocol

🔹 Adverse Reaction Orders

☑ Premier Infusion Center Protocol (premierinfusioncenter.com)
☐ Other (fax preferred reaction orders to 405-442-7223)

Pre-medications

- ☐ Acetaminophen: ☐ 500 mg ☐ 1000 mg ☐ PO
- ☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
- ☐ Solu-Medrol: ☐ 125 mg ☐ IV
- ☐ Other: _____ Dose: _____ Route: _____

Lab Monitoring

☐ CBC ☐ CMP ☐ CRP ☐ Lipid Panel ☐ LFTs ☐ Other: _____
☐ Frequency: ☐ Each dose ☐ Monthly ☐ Other: _____
☐ Physician office will order labs only

Clinical Documentation Checklist

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list

Ordering Provider & Demographics

- Name: _____ NPI: _____
- License #: _____
- Contact: _____ Phone: _____ Fax: _____
- Email: _____
- Signature: _____ Date: ____ / ____ / ____