Phone: (305) 306-7147 | Fax: (305) 402-9559 | Email: contact@clearwellinfusion.com

Clearwell
Infusion Centers

ACTEMRA (tocilizumab)

PATIENT DEMOGRAPHICS

Patient Name: _____
Date of Birth: _____ M: ☐ F: ☐ Address: _____
Phone: _____ City, State, Zip: _____
Email: _____

Allergies:

PRIMARY DIAGNOSIS

ICD-10 Code:

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

☐ TB Status and date (attach results)
☐ CBC with differential, Platelets, AST, ALT, and Lipid panel within 60 days
☐ CBC with differential, Platelets, AST, ALT at 2nd infusion, then every 12 weeks. Lipid panel at 2nd infusion, then every six months

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ Loratadine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ Other:

PRIMARY MEDICATION ORDER

Dosage:

☐ Initial dose of 4mg/kg every 4 weeks for _____ treatments then 8mg/kg every 4 weeks (induction dosing)
☐ 4mg/kg every 4 weeks
☐ 8mg/kg every 4 weeks

☐ Actemra (tocilizumab) Autoinjector:162mg/0.9mL every _____ week/s for _____ treatments

Patient Weight: _____ lbs _____ kg

NOTES

ORDERING PROVIDER

Provider Name: _____ NPI: _____
Practice Name: _____ Phone: _____
Office Contact: _____ Fax: _____
Practice Address: _____
City, State, Zip: _____

Provider Signature: _____ Date: _____