CURBSIDE INFUSION SERVICES

Fax To: 281-406-1047
Email To: referrals@curbsideinfusion.com
Office: 281-406-1046

ACTEMRA (tocilizumab) infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Rheumatoid Arthritis (RA)
- ☐ _____ Giant Cell Arthritis (GCA)
- ☐ _____ Polyarticular Idiopathic Arthritis in > 2yro (PJIA)
- ☐ _____ Systemic Juvenile Idiopathic Arthritis (SJIA)
- ☐ _____ Cytokine Release Syndrome (CRS)
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Cetirizine 10mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Quzyttir 10mg IVSP over 1-2 min
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

ACTEMRA ORDERS

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
- ☐ other:

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

v1.7 Copyright 2019, Intellectual Property of WeInfuse , LLC