IV INFUSION Treatment Center

FAX REFERRAL: **800-970-6020**

ACTEMRA® tocilizumab

Actemra Referral Checklist

Date: ___/___/___.

Referring Physician: _____.

Physician's Telephone #: _____ Facsimile #: _____.

Patient's Name: _____ Date of Birth: ___/___/___.

- ☐ Patient Demographics
- ☐ Most Recent Office Visit Note
- ☐ Most recent Tb test. If not completed, patient can receive it at our office
- ☐ Diagnosis:
  - ☐ Rheumatoid Arthritis – Please specify ICD 10 diagnosis
    - ☐ M05.7-
    - ☐ M05.69
    - ☐ M05.89
    - ☐ M05.9
    - ☐ M06.09

Dosage: Weight Based

- ☐ Initiation – Actemra 4 mg/kg IV Q 4 weeks for _____ dose(s)
- ☐ Maintenance – Actemra 4 – 8 mg/kg IV Q 4 weeks

Please specify dosage: ____mg/kg IV Q 4 weeks

Office Staff Name: _____ Signature _____.