Email: intake@infuseone.com | Phone: 1-800-581-0645 |
Please refer to website www.infuseone.com for location specific fax numbers

INFUSE ONE

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
- ☐ _____
- ☐ 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

PATIENT WEIGHT

_____lbs.

_____kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____