Actemra ® | (Tocilizumab)

Please fax a copy of the following patient information:

☐ Demographics ☐ Insurance information ☐Current Lab Results ☐H&P ☐ Current Medication

Patient Information

Patient Name:____ DOB:____________________

Allergies:__________________________________ Weight: _________ lbs/kg Height:___________

Diagnosis/ ICD-10:

☐ Rheumatoid arthritis, unspecified / M06.9

☐ Other giant cell arteritis / M31.6

☐ Systemic Sclerosis-Associated Interstitial Lung Disease / M34.81

☐ Polyarticular Juvenile Idiopathic Arthritis / M08.09

☐ Other (please specify) __________________________________

Additional information:

____

Provider Information

Printed Provider's Name:

____

Phone: _____________________________ Fax:_______________________________________

Office Address:

____

Contact Person:____

Medication Information

Dose:_______________________________________ Frequency and Duration: ________________

Start Date of Infusion:___________________ End Date of Infusion:________________________

Other Orders or Special Instructions:

____