UNIVERSITY OF MICHIGAN HEALTH-WEST
MICHIGAN MEDICINE
Infusion Center

Actemra IV Infusion

Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes**.

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ DOB: _____/_____/_____

Allergies: _____ Patient Weight: _____lbs/kg Height: _____

ICD-10: _____, _____, _____

In the past year, what medications for the above diagnosis has the patient tried and failed?

Drug	Dose	Dates of use

Will the patient be receiving other biologic therapy in combination with Actemra? ☐ No ☐ Yes

If yes to above, please provide rational for use:_____

TB verification *(check one):* ☐ **TB skin test** ☐ **TB spot/Quantiferon blood test** ☐ **Chest X-ray**

Result Date _____/_____/_____ Result *(check one)*: ☐ Positive ☐ Negative

Labs to be collected: ☐ BMP ☐ CMP ☐ CBC w/o diff ☐ CBC w/diff ☐ CRP ☐ ESR ☐ Hepatic panel ☐ _____

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ Other:_____

Actemra (tocilizumab) IV

Maximum dose is 800 mg

☐ **4mg/kg** ☐ **6mg/kg** ☐ **8mg/kg** ☐ **10mg/kg** ☐ **12mg/kg** ☐ **_____mg**

Frequency: ☐ **q 2 wks** ☐ **q 4 wks** ☐ **q_____wks**

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: ( ) _____ Office Fax Number: ( ) _____

Contact Name: _____ Contact Phone Number: ( ) _____

New referring providers, how did you hear about us?

☐ Web Search ☐ Pharma Rep ☐ Drug Locator ☐ Patient ☐ Word of Mouth ☐ IA Clinical Liaison ☐ IA Website ☐ Facebook
☐ Instagram ☐ Other: _____

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