MIC | METRO INFUSION CENTER

**Phone: 877.448.3627**

**Fax completed form to:**
**866-507-1164**

# INFUSION ORDERS — ACTEMRA

**Date of referral:** _____

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code:_____

Phone: _____ WT (kg): _____ HT: _____(in)

Diagnosis:_____

Allergies: _____ TB Test: _____

***ICD 10 CODE:** _____

***Please include supporting clinical documentation for specified ICD 10 Code as well as demographic and insurance information. This must be provided to ensure payment by insurance carrier. Please fax with this order form.**

## ACTEMRA DOSING

- ☐ Actemra 4mg/kg IV Q 4 weeks: Refills for 1 year
- ☐ Actemra 8mg/kg IV Q 4 weeks: Refills for 1 year

Prescribing Physician: _____

Address: _____

Physician Signature: _____

Date:_____

Physician Phone: _____ Fax: _____