MIC | METRO INFUSION CENTER

INFUSION ORDERS-ACTEMRA (TOCILIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Rheumatoid Arthritis	ICD 10 Code: M06.9
☐ Systemic Juvenile Idiopathic Arthritis (SJIA)	ICD 10 Code: M08.09
☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA)	ICD 10 Code: _____
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ TB Test Results	
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	

MEDICATION ORDERS**	
Rheumatoid Arthritis Dosing	☐ Actemra 4mg/kg IV every 4 weeks ☐ Actemra 8mg/kg IV every 4 weeks ☐ Actemra _____mg IV every 4 weeks Please note that doses >800mg for RA are not recommended.
SJIA Dosing	☐ Actemra 12mg/kg IV every 4 weeks (for patients weighing <30kg) ☐ Actemra 8mg/kg IV every 4 weeks (for patients weighing ≥ 30kg)
PJIA Dosing	☐ Actemra 10mg/kg IV every 4 weeks (for patients weighing <30kg) ☐ Actemra 8mg/kg IV every 4 weeks (for patients weighing ≥ 30kg)
Patient Weight = _____ kg	**Patient weight required for weight-based orders.
Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses	

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Revised 06/12/24