sage infusion

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(tocilizumab)

ACTEMRA 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 _____ mg every 4 weeks, then _____ mg every 4 weeks (induction)
- ○ _____ mg every 4 weeks
- ○ Notify if patient weight changes by _____ lbs. / kg (please circle)

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____