

ACTEMRA® (tocilizumab) Referral Form



www.biohealthic.com | info@biohealthic.com

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:		Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:	
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

Infusion to be administered per BioHealth protocols.

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- CRP at each dose every _____
- OTHER _____

PREMEDICATIONS

- acetaminophen (Tylenol) 500mg 650mg / 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg 50mg PO IV
- methylprednisolone (Solu-Medrol) 40mg 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____
- Dose: _____ Route: _____
- Frequency: _____

ACTEMRA THERAPY ADMINISTRATION

- 4mg/kg IV every 4 weeks with max dose of 800 mg for weight >200 kg
- 6mg/kg IV every 4 weeks with max dose of 600 mg for weight >100kg
- *GCA ONLY**
- 8 mg/kg IV every 4 weeks with max dose of 800 mg for weight >100kg.

REQUIRED DOCUMENTATION

- | | |
|-------------------------------------|---|
| Patient Demographics | Hep B Surface Antigen (within 36months) |
| Insurance card/Information | TB results (within 6 months) |
| Progress Notes supporting DX | Comprehensive Metabolic Panel |
| Medication List and H&P | |

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) Provider Signature Date

Have a Question? (786)460-6044
Fax Referral Form To: (786)219-3917
8684 SUNSET DRIVE MIAMI FL 33143