



Nucara Pharmacy Nucara Infusion Center
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 Austin, TX 78757 Austin, TX 78757
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 Fax: 512-524-1801 Fax: 512-524-1801

Patient Name: _____

DOB: _____ Wt(kg): _____

Allergies: _____ Phone: _____

Actemra (Tocilizumab) Infusion Orders

Required Information:

Signed order from prescribing provider
 Patient demographics including insurance information
 Supporting clinical documentation: Visit notes, lab & imaging results
 Last TB and Hepatitis B results

Primary Diagnosis:

Rheumatoid Arthritis (ICD-10: _____)

Other: _____ (ICD-10: _____)

ACTEMRA ORDERS

Initial Dose: Actemra 4mg/kg

Other: _____ mg every 4 weeks

---OR---

Subsequent Doses: 8mg/kg every 4 weeks

DOSE NOT TO EXCEED 800MG

Administered per manufacturer guidelines

PRE-MEDICATIONS

PO Tylenol _____ mg

PO Loratadine _____ mg

PO Cetirizine _____ mg

PO IV Diphenhydramine _____ mg

IV Solu-medrol _____ mg

PO IV Other: _____ mg

LABS

CBC

ESR

Uric Acid

Frequency:

Every Infusion

CMP

TB Quantiferon Gold

Other: _____

Every Other Infusion

CRP

Hep B Core/Surface AG

Other: _____

One time only

Other: _____

CPL Acct #: _____

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

Physician Name:

Phone:

Fax:

Physician Signature:

NPI:

Date: