

# MPP Infusion Centers

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Have a Question? Call: (855) 478-1528

A Multispecialty Physician Partner Company

## ACTEMRA® (TOCILIZUMAB) ORDER FORM

REFERRAL STATUS			
<input type="checkbox"/> New Referral <input type="checkbox"/> Order Renewal <input type="checkbox"/> Restart <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> D/C Infusion (Medication(s) to D/C _____)			
LOCATION			
<input type="checkbox"/> Denver <input type="checkbox"/> Arlington <input type="checkbox"/> Dallas <input type="checkbox"/> Duncanville <input type="checkbox"/> Irving <input type="checkbox"/> Lewisville <input type="checkbox"/> Plano <input type="checkbox"/> Southlake <input type="checkbox"/> Tyler			
PATIENT INFORMATION			
PATIENT NAME:		DOB:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS:		PHONE #:	
WEIGHT: _____ LBS    _____ KG	HEIGHT:	EMAIL:	
ALLERGIES:			
<b>Please check that the following are included</b>	<input type="checkbox"/> Patient demographics and insurance attached		<input type="checkbox"/> Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
	<input type="checkbox"/> Current Medication List		<input type="checkbox"/> Comprehensive Metabolic Panel, CBC with differential if available
	<input type="checkbox"/> HepB Core (w/in 36 months)	<input type="checkbox"/> TB Results (w/in 6 months) - if positive, need negative chest Xray and negative TSpot.	
PHYSICIAN INFORMATION			
Physician Name:		Email (if you would like referral updates):	
Practice Name:		Phone Number:	
Office Contact:		Fax Number:	
DIAGNOSIS			
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Cytokine Release Syndrome		
<input type="checkbox"/> Other:			
ICD-10 CODE:		Date of last infusion/injection:	
MEDICATION ORDERS			
<b>ACTEMRA ORDERS:</b>			<b>Notes/Comments</b>
Dosing: _____ mg/kg IV every _____ weeks			
Physician Signature _____ Date (Order is Valid for One Year) _____ Infusion will be administered per MPP policy and protocol			
STANDING LAB ORDERS			
<input type="checkbox"/> Labs to be Drawn by Infusion Center		Frequency: <input type="checkbox"/> Every Infusion <input type="checkbox"/> Other (please specify) _____	
<input type="checkbox"/> CMP <input type="checkbox"/> CBC <input type="checkbox"/> CRP <input type="checkbox"/> ESRP <input type="checkbox"/> HFR <input type="checkbox"/> UA			
MPP ACTEMRA ORDER FORM_01/2019			