MPP INFUSION CENTERS
www.mppinfusion.com

Fax Referrals To: (855) 891-2191
Email Referrals To: MPPReferral@mppinfusion.com
Have a Question? (855) 478-1528

ACTEMRA® (TOCILIZUMAB) ORDER FORM

(- Required Fields)*

☐ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

☐ **New Referral** ☐ **Order Renewal** ☐ **Medication/Order Change**
☐ **Benefits Verification Only** ☐ **Discontinuation Order**

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: ☐M ☐F
ADDRESS:		PHONE:	
WEIGHT: ☐LBS ☐KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

ACTEMRA ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: _____

☐ Dosing: _____mg/kg IV every _____ weeks

Physician Signature* _____ **Date*(Order is Valid for One Year)** _____
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

☐ Rheumatoid Arthritis
☐ Cytokine Release Syndrome
☐ Other_____

***STAT REASON:**
(STAT requests will be assessed per MPP policy and protocols)

Last Infusion/Injection Date: _____

REQUIRED DOCUMENTATION CHECKLIST:

☐ Patient Demographics
☐ Insurance Card/Information
☐ Clinical/Progress Notes supporting DX
☐ Current Medication List and H&P
☐ Comprehensive Metabolic Panel, CB with differential if available
☐ HepB Core (if available)
☐ HepB Surf Ag (w/in 36 months)
☐ TB Results (w/in 6 months)
If positive, need negative chest Xray and negative TSpot

STANDING LAB ORDERS: ☐ CMP ☐ CBC

☐ Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

Locations:

--------**Colorado**--------
☐ Lakewood

--------**Florida**---------
☐ Jacksonville
☐ Kissimmee
☐ Port St. Lucie
☐ Suncoast
☐ Winter Park

----------**Texas**----------
☐ Arlington
☐ Cedar Hill
☐ Dallas
☐ Denton
☐ Ft. Worth
☐ Irving
☐ Rockwall
☐ Southlake
☐ Flower Mound
☐ Plano
☐ Tyler

REVISION DATE- 3/2021