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

-------**Oklahoma**-------
___ Tulsa

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

REVISION DATE- 9/2021