

Patient's Information

Date of Referral

First Name

Last Name

M.I.

Date of Birth

Address

City

State

ZIP Code

Phone

WT (kg)

HT (in)

Diagnosis

Allergies

***Please fax most recent labs and TB results and date.**

*ICD 10 CODE

*** Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

ACTEMRA DOSING

Actemra 4mg/kg IV Q 4 weeks: Refills for 1 year

Actemra 8mg/kg IV Q 4 weeks: Refills for 1 year

Actemra different dosing than above:

Refills:

Prescribing Provider

Address

City

State

ZIP Code

Provider
Signature

Date

Provider Phone

Provider Fax