



Northwest Rheumatology Associates, P.C.
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ACTEMRA ORDER

Patient Name: _____ DOB: _____ Date: _____

Patient demographics, (address, phone)

Copy front and back of all insurance cards

Actemra is given at 4mg/kg. Please round up or down to nearest vial.

Dose of Actemra IV	Frequency of Doses
<input type="checkbox"/> _____MG	<input type="checkbox"/> Loading doses at week 4 then Q 4 weeks thereafter
<input type="checkbox"/> _____MG	<input type="checkbox"/> Dose every 4 weeks

Prior to IV infusion/injection confirm the following:

Patient weight: _____ lbs & _____ kgs

ICD-10 Code: _____

CPT Code: J3262

Expires one calendar year from date or: _____

Ordering physician signature: _____

Ordering physician printed name: _____

Ordering physician phone number: _____

Ordering physician fax number: _____

Please note all boxes must be checked off for us to schedule your patient for treatment. Please fax this information to (503) 297-0863 Attn: Patient Resource Team. Please call with any questions at (503) 297-3384