# Actemra® IV

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

## PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

**Patient Status:** ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

**INSURANCE INFORMATION:** ***Please attach copy of insurance card (front and back).***

## DIAGNOSIS*

***ICD 10 Code Required***

☐ Rheumatoid Arthritis (M05.70-M05.9, M06.00-M06.09, M06.9), ICD10 _____

☐ Juvenile Idiopathic Arthritis (M08.00-M08.99), ICD10 _____

☐ Giant Cell Arteritis (M31.5, M31.6), ICD10 _____

☐ Other: _____, ICD10 _____

## INFUSION ORDERS

| MEDICATION | DOSE | DIRECTIONS/DURATION |
|---|---|---|
| Actemra® IV (tocilizumab) | ☐ _____ mg (4 mg/kg)<br>☐ _____ mg (8 mg/kg)<br>☐ _____ mg (____ mg/kg) | ☐ Infuse IV over 1 hour every 4 weeks x 1 year<br>☐ Infuse IV over 1 hour every _____ weeks x 1 year |

**Is patient currently receiving therapy above from another facility?**

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment:_____ Date of next treatment:_____

### PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: _____

### LAB ORDERS

**Labs to be drawn by:** ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____

☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

## REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI:_____ Specialty:_____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

## REQUIRED CLINICAL DOCUMENTATION

**Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.**

### LAB AND TEST RESULTS (required)

- TB screening (submit results from within 12 months to start therapy and annually to continue therapy)
  - Annual TB screening to be done by**:** ☐ Infusion Center ☐ Referring Physician
- Hepatitis B Screening (submit results to start therapy)

### PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____