

ACTEMRA (TOCILIZUMAB)

Order Form

DHONE 515 225 2930 | **FAX** 515 559 2495

		PHONE	= 313.223.2930 T	
Patient Information			Demogra	aphics Attached
Patient Name:	D	OOB:	Phone:	
INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back).				
Medical Information				
J Code: J3262 Diagnosis: Rheumatoid Arthritis		ICD-10 Code	:	
Other		ICD-10 Code	•	
Patient Weight:lbs.				
Allergies:				
Clinical/progress notes, labs and tests supporting primary diagnos	is attached			
Date of Last TB/CXR:	ppy of documentation	attached		
Labs: Required labs to be drawn by: Infusion Center	Referrin	g Provider		
Lab Orders:				
TB and Hepatitis B Documentation attached				
Hepatitis B Protocol: Hep B surface antigen and Heb B Core AB total ITB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD	required	Vearly TR Scr	reening (<i>optional</i>)	
TET TOLOGO. Buschine testing. Quantilition Gold (QLT Gold) GTT E		really 15 Ser	cerning (optionar)	
Actemra Orders				
Actemra: 4 mg/kg IV every 4 weeks for	doses, then	followed by 8 mg/k	kg IV every 4 weeks therea	fter
4 mg/kg IV every 4 weeks 8 mg/kg IV every 4 weeks				
Other dose: mg IV every 4 weeks				
	EXCEED 800 MG IN F	RA DIAGNOSIS***		
Protocol: Labs per diagnosis as follows:				
All dx: Obtain CBC w/ diff, LFTs and Lipid Panel prior to 1st infusion				
RA: CBC w/ diff, LFTs and Lipid Panel prior to 3rd infusion All subsequent infusions – CBC w/ diff q 3 mos, LFTs q 4-8 weeks for 1st 6 mos, then q 3 mos and Lipid Panel q 6 mos				
PJIA: CBC w/ diff, LFTs and Lipid Panel prior to 2nd dose, then CBC w/ diff, LFTs q 4-8 weeks and Lipid Panel q 6 months				
SJIA: CBC w/ diff, LFTs and Lipid Panel prior to 2nd dose, then CBC w/ diff, LFTs q 2-4 weeks and Lipid Panel q 6 months				
Additional Orders / Comments:				
Physician Information				
Physician Information By signing this form and utilizing our services, you are authorizing <i>Hy</i>	Voo Hog/th and its or	mployoos to soryo a	s vour prior authorization	and specialty pharmacy
designated agent in dealing with medical and prescription insurance		ripioyees to serve a	s your prior authorization (and specialty pharmacy
Provider Name:	Signature:		Date	ə:
Provider NPI: Phone:	Fax:		Contact Person:	
Service Areas				
Des Moines, IA West Des Moines, IA	Chicago, IL	Omaha, NE	Buffalo, NY	Dallas, TX
	Cilicago, IL	Orriaria, INE	DullalU, NY	Dallas, IA
Phoenix, AZ Other				

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