ACTEMRA (TOCILIZUMAB) Order Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

☐ **Demographics Attached**

Patient Name: _____ **DOB:** _____ **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 diagnosis attached

Date of Last TB/CXR: _____ ☐ Copy of documentation attached

Labs: Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Lab Orders: _____

☐ TB and Hepatitis B Documentation attached

Hepatitis B Protocol: Hep B surface antigen and Heb B Core AB total required

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD ☐ Yearly TB Screening (*optional*)

Actemra Orders

Actemra: ☐ 4 mg/kg IV every 4 weeks for _____ doses, then followed by 8 mg/kg IV every 4 weeks thereafter

☐ 4 mg/kg IV every 4 weeks

☐ 8 mg/kg IV every 4 weeks

☐ Other dose: _____ mg IV every 4 weeks

*****DOSE NOT TO EXCEED 800 MG IN 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

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

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