



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____		Prescriber Name: _____ State License: _____ NPI #: _____ Tax ID: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____	
<b>INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front &amp; back)</b>			
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	
<b>CLINICAL INFORMATION</b>			
Primary ICD-10 Code (Please Specify Diagnosis): _____ Secondary ICD-10 Code (Please Specify Diagnosis): _____ Date of negative TB test: _____ <input type="checkbox"/> TB test pending, will fax results. Patient is HBV negative or has been treated: <input type="checkbox"/> Yes <input type="checkbox"/> No History of kidney disease: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, SCr: _____ GFR/CrCl: _____ History of heart failure: <input type="checkbox"/> Yes <input type="checkbox"/> No Required labs: <input type="checkbox"/> ANC: _____ <input type="checkbox"/> Platelet: _____ <input type="checkbox"/> AST: _____ Upper limit of normal: _____ <input type="checkbox"/> ALT: _____ Upper limit of normal: _____ Obtain the following labs at prior to start of treatment and at _____ frequency: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFTs <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: _____			
<b>ACTEMRA® ORDERS</b>			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____			
<b>Medication</b>	<b>Strength</b>	<b>Dose/Frequency</b>	<b>Refills</b>
<input type="checkbox"/> Actemra (Tocilizumab)	<input type="checkbox"/> 20mg/mL vial <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4mg/kg IV every 4 weeks with max dose of 800 mg <input type="checkbox"/> 6mg/kg IV every 4 weeks with max dose of 800 mg <input type="checkbox"/> 8 mg/kg IV every 4 weeks with max dose of 800 mg <input type="checkbox"/> Other: _____	_____
<b>Pre- Medication</b>	<b>Route</b>	<b>Dose</b>	
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg	
<input type="checkbox"/> Methylprednisolone (Solu-Medrol)	<input type="checkbox"/> IV	<input type="checkbox"/> 60mg <input type="checkbox"/> 100 mg <input type="checkbox"/> _____mg	
<input type="checkbox"/> Diphenhydramine (Benadryl)	<input type="checkbox"/> IV <input type="checkbox"/> PO	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	
Other: _____			
<b>ANAPHYLACTIC REACTION (AR):</b>			
<input type="checkbox"/> EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg); may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary <input type="checkbox"/> Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access			

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**ACTEMRA®**

**Please Fax Completed Form To: 888-898-9113**

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr

☐ Other: \_\_\_\_\_

**SIGNATURE**

We hereby authorize Valustar to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X \_\_\_\_\_

Prescriber Signature

Date: \_\_\_\_\_

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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