# ACTEMRA®

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

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

## PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

## PRESCRIBER INFORMATION

Prescriber Name: _____

State License: _____

NPI #: _____ Tax ID: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Office Contact: _____ Phone: _____

## INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

## CLINICAL INFORMATION

Primary ICD-10 Code (Please Specify Diagnosis): _____

Secondary ICD-10 Code (Please Specify Diagnosis): _____

Date of negative TB test: _____ ☐ TB test pending, will fax results. Patient is HBV negative or has been treated: ☐ Yes ☐ No

History of kidney disease: ☐ Yes ☐ No *If yes*, SCr: _____ GFR/CrCl: _____ History of heart failure: ☐ Yes ☐ No

Required labs: ☐ ANC: _____ ☐ Platelet: _____ ☐ AST: _____ Upper limit of normal: _____ ☐ ALT: _____ Upper limit of normal: _____

Obtain the following labs at prior to start of treatment and at _____ frequency: ☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ LFTs ☐ X-Ray ☐ Other: _____

## ACTEMRA® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

| Medication | Strength | Dose/Frequency | Refills |
|---|---|---|---|
| ☐ Actemra (Tocilizumab) | ☐ 20mg/mL vial<br>☐ Other: _____ | ☐ 4mg/kg IV every 4 weeks with max dose of 800 mg<br>☐ 6mg/kg IV every 4 weeks with max dose of 800 mg<br>☐ 8 mg/kg IV every 4 weeks with max dose of 800 mg<br>☐ Other: _____ | _____ |

| Pre- Medication | Route | Dose |
|---|---|---|
| ☐ Acetaminophen | ☐ PO | ☐ 500mg ☐ 650mg ☐ 1000mg |
| ☐ Methylprednisolone (Solu-Medrol) | ☐ IV | ☐ 60mg ☐ 100 mg ☐ _____mg |
| ☐ Diphenhydramine (Benadryl) | ☐ IV ☐ PO | ☐ 25mg ☐ 50mg |
| Other: _____ | _____ | _____ |

## ANAPHYLACTIC REACTION (AR):

☐ 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

☐ 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

☐ Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary

☐ Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access

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☐ 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_____ Date: _____

Prescriber Signature

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.