ACTEMRA (TOCILIZUMAB) INFUSION ORDERS

VITAL CARE
OF NORTH HOUSTON

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PATIENT INFORMATION

Name _____ DOB _____ Emergency Contact _____

INSURANCE INFORMATION: PLEASE ATTACH A COPY OF INSURANCE CARD, 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, Tests supporting primary diagnosis attached

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

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

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:

☐ Initial: 4mg/kg IV q 4 weeks, followed by 8 mg/kg IV q 4 weeks

☐ 4mg/kg IV every 4 weeks

☐ 8mg/kg IV every 4 weeks

☐ Other dose: _____ mg IV every 4 weeks

DOSE NOT TO EXCEED 800MG

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 VITAL CARE and its employees to serve as your prior Authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature _____ Date _____

Physician Name _____

Phone _____ Fax _____ Contact Person _____