ACTEMRA® Adult Infusion Form

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ○ M ○ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ○ N ○ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Clinical Information – Please fax with Infusion Order Form and other requested items below:

- Clinical MD Notes, labs, test supporting primary diagnosis
  - TB Screening Results
  - Hepatitis B Screening (including Hep B surface antigen & Hep B Core Antibody)
  - Recent Lab Results (including CBC with diff, LFTs, Platelets, & Lipid Panel)
- Previous Drug Therapy History, including therapies trailed/failed and date of last administration:

  Agent: _____ Date: _____ Desired Washout Period: _____ weeks

Infusion Center – Lab Orders: (Check for Infusion Center to Manage):

❑ CBC with diff, Platelets, and LFTs prior to second infusion and then every 12 weeks thereafter

Lipid Panel prior to the second infusion and then every six months

Please attach the following: 1. List of current Medications, 2. Copy of the patient's Insurance Card, 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs

Physician Information

Prescribing Physician: _____ Practice Name: _____

Practice Phone: _____ Practice Fax: _____

Email: _____ Office Contact: _____

Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **ACTEMRA® (tocilizumab)**

Administer Actemra IV over 1 hour. ***Select Dose Below***

Induction Dose:

☐ 4 mg/kg IV

Maintenance Dose: _____#Refills (Recommend 6)

☐ 4 mg/kg IV every 4 weeks

☐ 8 mg/kg IV every 4 weeks (**Dose not to exceed 800 mg**)

☐ Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____

Physician's NPI# Physician's Address

_____ _____

Prescriber's Signature Date