

**INFUSION & MEDICAL CENTER**

**1. Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Patient Phone/Cell #** \_\_\_\_\_  
**Patient demographic and insurance information to be faxed with Infusion Order Form**

**2. Medical Information (Please select primary diagnosis and complete ICD10 Code):**  
 Primary Diagnosis: \_\_\_\_\_ Rheumatoid Arthritis with Rheumatoid factor ICD-10 Code: M05. \_\_\_\_\_  
 \_\_\_\_\_ Rheumatoid Arthritis without Rheumatoid factor ICD-10 Code: M06. \_\_\_\_\_  
 \_\_\_\_\_ Other: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ (or attach list)

<b>Patient</b>
<b>Weight:</b> _____ lbs.
<b>Height:</b> _____ in.

**3. Clinical Information – Please fax with Infusion Order Form:**

- 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

**ACTEMRA® (tocilizumab)** J Code: J3262

**4. Drug Order:**  
 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 this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

**5. Physician Signature:** \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_  
 Dispense as written Substitution permitted

Printed Physician's Name: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

<b>FAX ALL INFORMATION</b> <b>CENTRAL FAX 803.999.1754</b> <b>ALTERNATE FAX 803.999.1887</b>	<b>INFUSION CENTER LOCATIONS</b> <b>COLUMBIA CHARLESTON GREENVILLE</b> <b>CENTRAL INTAKE PHONE 800.767.6337</b>
--	---