INTRAMED Plus
infusion services

ACTEMRA®
Pediatrics (> 2 y.o.)

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: _____ Juvenile Rheumatoid Arthritis with Systemic Onset ICD-10 Code: M08.2 _____

_____ Juvenile Rheumatoid Polyarthritis (seronegative) ICD-10 Code: M08.3 _____

_____ Other:_____ ICD-10 Code: _____

Allergies:_____ (or attach list)

Patient
Weight: _____ lbs.
Height:_____ 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 every _____ weeks.
❑ 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***

For Polyarticular JIA – Infuse every 4 weeks _____#Refills (Recommend 5)
- ❑ Less Than 30 kg weight: **10 mg/kg**
- ❑ 30 kg or above weight: **8 mg/kg**

For Systemic JIA – Infuse every 2 weeks _____#Refills (Recommend 10)
- ❑ Less Than 30 kg weight: **12 mg/kg**
- ❑ 30 kg or above weight: **8 mg/kg**

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 #: _____

FAX ALL INFORMATION	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	**COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**