

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)

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 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 #: _____

FAX ALL INFORMATION CENTRAL FAX 803.999.1754 ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1960
--	---