immersiv HEALTH

ACTEMRA® PEDS ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

***PLEASE COMPLETE ICD-10 FOR SPECIFIC DIAGNOSIS**

☐ M08.2 Juvenile Rheumatoid Arthritis w/ Systemic Onset

☐ M08.3 Juvenile Rheumatoid Polyarthritis (seronegative)

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Most recent History & Physical ☐ Tried & Failed Therapies ☐ Negative TB Screening ☐ Negative Hep-B Screening

☐ Liver Function Test results ☐ Recent CBC w/ diff

MEDICATION ORDER

***Tocilizumab - Actemra or biosimilar (Tyenne) may be used according to payor guidelines**

To restrict substitution, indicate required brand here: _____

For Polyarticular JIA

☐ **< 30 kg**: Tocilizumab 10 mg/kg IV in 50 ml NS over 60 minutes every 4 weeks (no less than 28 days)

☐ **≥ 30 kg**: Tocilizumab 8 mg/kg IV in 100 ml NS over 60 minutes every 4 weeks (no less than 28 days)

For Systemic JIA

☐ **< 30 kg:** Tocilizumab 12 mg/kg IV in 100 ml NS over 60 minutes every 2 weeks (no less than 14 days)

☐ **≥ 30 kg:** Tocilizumab 8 mg/kg IV in 100 ml NS over 60 minutes every 2 weeks (no less than 14 days)

☐ **OTHER:** _____

PRE-MEDICATIONS

PO

☐ Acetaminophen: 650 mg

☐ Cetirizine: 10 mg

☐ Diphenhydramine: 25 mg

IV

☐ Methylprednisolone: 125 mg

☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

LAB ORDERS

CBC w/ diff, Platelets, AST and ALT at 2nd infusion, then every 4 weeks

Lipid panel at 2nd infusion, then every 6 months

OTHER LAB: _____ FREQUENCY: _____

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first infusion.

In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: (IF APPLICABLE) _____ **CONTACT NAME:** _____

SIGNATURE: (NO STAMPS) _____ _____ **DATE:** _____

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN