immersiv HEALTH

ACTEMRA® 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**

☐ M05.____ Rheumatoid arthritis, with Rheumatoid factor

☐ M06.____ Rheumatoid arthritis, without Rheumatoid factor

☐ M31.5 Giant cell arteritis w/ polymyalgia rheumatica

☐ M31.6 Other giant cell arteritis

☐ 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 Rheumatoid Arthritis

☐ Tocilizumab 4 mg/kg IV in 100 ml NS over 60 minutes every 4 weeks (max dose 800 mg)

☐ Tocilizumab 8 mg/kg IV in 100 ml NS over 60 minutes every 4 weeks (max dose 800 mg)

For Giant Cell Arteritis

☐ Tocilizumab 6 mg/kg IV in 100 ml NS over 60 minutes every 4 weeks (max dose 600 mg)

☐ **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 12 weeks

Lipid panel at 2nd infusion, then every six 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