Actemra

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable):

REQUIRED DOCUMENTATION

◯ Labs ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

ICD-10 CODE

◯ M06.9 Rheumatoid arthritis
◯ M08. 40 Polyarticular juvenile idiopathic arthritis
◯ M31.6 Giant Cell arteritis
◯ D89.839 Cytokine release syndrome, grade unspecified
◯ M34. 81 Systemic sclerosis associated interstitial lung disease
◯ Other: ____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ◯ 500mg ◯ 650mg ◯ 1000mg PO

Diphenhydramine (Benadryl) ◯ 25mg ◯ 50mg ◯ PO ◯ IV

Cetirizine (Zyrtec) ◯ 10mg PO

Methylprednisolone (Solu-Medrol) ◯ 40mg IV ◯ 125mg IV

Loratadine (Claritin) ◯ 10mg PO

Hydrocortisone (Solu-Cortef) ◯ 100mg IV

Other: ____________________________________ Dose:________________ Route:________________ Frequency: ________________

MEDICATION ORDER

◯ **No brand preference. Health Infusion Services will select product based on payer policy** ◯ Brand preference: ________________________________

Dose (IV Infusion): ◯ 4mg/kg IV ◯ 6mg/kg IV ◯ 8mg/kg IV ◯ 10mg/kg IV ◯ 12mg/kg IV ◯ Other: ____________________ mg/kg IV

◯ round up to the nearest whole vial ◯ give exact dose

Frequency (IV Infusion): ◯ every 2 weeks ◯ every 4 weeks ◯ **Other:** ____

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

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______________________	______________________	______________________
Provider Name	**Provider Signature**	**Date** ◯ **Check here if this is a stat order**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.