INTRAMED Plus
infusion services

ACTEMRA®
Adult

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 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

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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.

Pre-Medication Orders: _____

No Pre-medications are recommended based on manufacturer guidelines.

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**	**INFUSION CENTER LOCATIONS** **BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**