INTRAMED Plus
infusion services

ACTEMRA®
Pediatrics (> 2 y.o.)

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 ICD-10 Code):

Primary Diagnosis: _____ Juvenile Rheumatoid Arthritis with Systemic Onset ICD-10 Code: M08.2 _____

_____ Juvenile Rheumatoid Polyarthritis (seronegative) ICD-10 Code: M08.3 _____

_____ Other: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

Patient
Weight: _____ lbs.
Height _____ in.

- Clinical notes, labs, test supporting primary diagnosis
  - o TB Screening Results
  - o Hepatitis B Screening (including Hep B surface antigen & Hep B Core Antibody)
  - o 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 _____ 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***

For Polyarticular JIA – Infuse every 4 weeks _____ #Refills (Recommend 5)

❑ Less Than 30 kg weight: **10 mg/kg**

❑ 30 kg or above weight: **8 mg/kg**

For Systemic JIA – Infuse every 2 weeks _____ #Refills (Recommend 10)

❑ Less Than 30 kg weight: **12 mg/kg**

❑ 30 kg or above weight: **8 mg/kg**

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 our 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 with Credentials: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**