Intravene -ACTEMRA Infusion Orders (rev 10/2018)

Please fax this form along with a copy of insurance cards to:
Fax (434) 455-5531 or Call (434) 947-3900 ext. 2172

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip code _____
Home Phone # _____
Work Phone # _____
DOB _____SSN _____Sex_____
Height _____ Weight _____
Allergies _____
Primary Insurance _____
Secondary Insurance _____

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address_____
_____
Physician Phone _____
Physician Fax _____
NPI# _____ DEA # _____
State License#_____

** ***Please fax copy of insurance cards*** ***and this form to (434)- 455-5531***

DIAGNOSIS: ICD-10 (required)

☐ _____ _____
☐ _____ _____
☐ _____ _____

PRE TREATMENT SCREENING:

Tuberculosis Screening: Date/Results of TB test_____
Hepatitis B Screening: Date/ Results:_____
Hepatitis C Screening: Date/Results:_____

PRIOR MEDICATIONS TRIED AND FAILED :

Is your patient currently taking or failed any of the following RA products?

Methotrexate--- Currently Taking☐ Failed☐ Date Failed _____
Leflunamide--- Currently Taking☐ Failed☐ Date Failed_____
Sulfasalazine--- Currently Taking☐ Failed☐ Date Failed_____
Humira---------- Currently Taking☐ Failed☐ Date Failed_____
Prednisone------ Currently Taking☐ Failed☐ Date Failed_____
Remicade------- Currently Taking☐ Failed☐ Date Failed_____
Orencia--------- Currently Taking☐ Failed☐ Date Failed_____
Enbrel---------- Currently Taking☐ Failed☐ Date Failed_____
Other_____ Currently Taking☐ Failed☐ Date Failed_____

STANDARD ORDERS

Infuse:_____mg/ kg in Normal Saline 100ml over 60 minutes for 1 year. Upon completion of Actemra infusion, infuse Normal Saline 20ml to clear line. (Note: Maximum dose is 800mg)
☐ Once every 4 weeks ☐ Other:_____ for 1 year

LABS: CBC and Liver Panel with each infusion
Lipid Panel to be drawn 4 weeks after initiation and then every 6 months
Other:_____

Anaphylactic meds and Vital Sign monitoring per Intravene Protocol

Signature, prescribing MD _____Date _____