**Nevada Infusion**
**5401 Longley Lane, Suite 34, Reno, NV 89511**
**PH: 775-453-0667 | Fax: 775-470-8478**

# Actemra Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

**DIAGNOSIS:**

- ☐ Rheumatoid Arthritis ICD-10:_____
- ☐ Polyarticular Juvenile Idiopathic Arthritis ICD-10:_____
- ☐ Systemic Juvenile Idiopathic Arthritis ICD-10:_____
- ☐ Acute Graft Versus Host Disease ICD-10:_____
- ☐ Giant Cell Arteritis ICD-10:_____
- ☐ CRS ICD-10 Code:_____
- ☐ Other_____ICD-10:_____

**ORDER FOR ACTEMRA (TOCILIZUMAB):**

- ☐ **4mg/kg IV every 4 weeks x _____doses, followed by 8mg/kg IV every 4 weeks thereafter x 1 year.**
- ☐ **4mg/kg IV every 4 weeks x 1 year.**
- ☐ **8mg/kg IV every 4 weeks x 1 year.**
- ☐ **Other:_____x 1 year.**

**PRE-MEDICATIONS:**

- ☑ Acetaminophen 650mg PO
- ☑ Diphenhydramine 25mg PO or IV Or Zyrtec 10 mg PO
- ☑ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☑ Additional Pre-Medications: _____

**MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:**

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

**PROVIDER INFORMATION:**

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

**Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478**

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

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**Please Include Required Documentation for Expedited Order Processing & Insurance Approval:**

☐ Signed Provider orders (page 1)
☐ Patient demographic and insurance information
☐ Patient's current medication list
☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

☐ Rheum - Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)?
☐ Yes ☐ No
If yes, which drug(s)? _____
☐ Rheum - Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Simponi, Xeljanz, infliximab)?
☐ Yes ☐ No
If yes, which drug(s)? _____

☐ CRS dx - Has the patient received treatment with a chimeric antigen receptor T cell therapy (i.e., Kymriah, Yescarta) or Blincyto?
☐ Yes ☐ No
If yes, which drug(s)? _____

☐ Include labs and/or test results to support diagnosis
☐ Rheumatoid Factor or anti-CCP (please attach results)
☐ Temporal artery biopsy or cross-sectional imaging or acute-phase reactant elevation (GCA dx)

☐ If applicable - Last known biological therapy: _____ and last date received: _____.
If the patient is switching to biologic therapies, please perform a wash-out period of _____ weeks prior to starting Actemra.

☐ Other medical necessity documentation (please include): _____

**Additional REQUIRED Information:**
☐ TB screening test completed within 12 months - please include results
☐ Positive OR ☐ Negative
☐ CBC w/diff, LFTs, Lipid Panel - please include results

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