Actemra (Tocilizumab)

☐ New Referral ☐ Continuing Treatment ☐ Medication Order Change

Patient Information:

Name:____
Date:____
DOB:____
SS#:____
Phone #:____
Email:____

Physician Information:

Referring Physician: ______________________________

Address:____
____

Phone #:____

Fax #:____

Medication Orders

Patient Weight: _______kg Patient Height: __________inches ☐ First Dose ☐ Maintenance Dose

Dosing: ☐ 4mg/kg IV for 1st infusion and then 8mg/kg every 4 weeks thereafter

☐ 8mg/kg IV every 4 weeks Premeds (if applicable): ☐ ____________ ☐ ____________

☐ 6mg/kg IV every 4 weeks

☐ 4mg/kg IV every 4 weeks

Indication / Diagnosis:
- ☐ M05.79 Rheumatoid arthritis with rheumatoid factor without organ or systems involvement
- ☐ M06.9 Rheumatoid arthritis, unspecified
- ☐ M31.6 Giant Cell Arteritis
- ☐ Other (please specify)______________ **ICD-10 (Required)** ________________________

MD Signature:________________________________**NPI#:** __________________ **Date:** ____________

Required Documentation

Please send the following documents and records. This will help streamline the pre-authorization process.
- **If this is a continuation of a treatment, include the last infusion note**
- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- Current medication list

Most recent diagnostics results to include:
- CMP/BMP
- CBC with differential
- TB test: QGT, TSpot (within 2 years) - if HX of TB or + QGT, need negative Chest Xray report sent
- Hepatitis C-Ab
- Hepatitis B-Core Ab, B SAg, B SAb

We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.

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