

Actemra



Ph: 518-836-3030 | Fax: 518-836-3020

Date: _____

Please include the following to expedite the order

Demographics, Insurance Information, Current CBC & CMP, Last Progress Note Relevant to the Diagnosis, Current Medications, Viral Hepatitis Results, TB Results

PATIENT INFORMATION

PRESCRIBER INFORMATION

Patient Name: _____

Prescriber's Name: _____

Patient Contact Number: _____

NPI: _____ Date: _____

DOB: _____

Phone: _____ Fax: _____

Allergies: _____

Office Address: _____

Weight: _____ ○ lbs ○ kg Height: _____

Contact Person: _____

Diagnosis: _____

Contact Email: _____

ICD 10: _____

☐ Please check this box if you **DO NOT** authorize UHO to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

PREMEDS

☐ No Premeds

Benadryl: ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

Acetaminophen: ☐ PO ☐ 650 mg ☐ Other: _____

Methylprednisolone: ☐ IV ☐ _____ mg

Other: _____

☐ You authorize UHO to utilize the hypersensitivity protocol established by UHO.

Signature: _____

Date: _____

ACTEMRA DOSAGE

Date of Last Treatment, if Continuation: _____

Route: ☐ IV

☐ 4 mg/kg ☐ 6 mg/kg ☐ 8 mg/kg | Every ☐ 4 weeks OR every ☐ 2 weeks

Total Dose: _____ mg Maximum Dose is 800 mg

Refills: ☐ 3 months ☐ 6 months

(if not indicated order will expire 6 months from date signed)

To ensure that a Brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, UHO is authorized to administer generic or biosimilar.

LAB ORDERS

☐ No Labs

List: _____

Frequency: _____

Signature: _____

Date: _____