

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. 3001

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# _____

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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 Signs monitoring per Intravene Protocol

Signature, prescribing MD _____ Date _____