Actemra

INFUSION FOR HEALTH
InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order. Demographics, Insurance Information, Current CBC & CMP, H&P Relevant to the Diagnosis, Current Medications, TB Results

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: ☐ M06.9 ☐ M31.6 ☐ M34.81 ☐ M08.3 ☐ M08.20 ☐ D89.83

Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

PREMEDS

☐ No Premeds

Benadryl:	☐ PO	☐ IV	☐ 25mg	☐ 50mg	☐ Pre-med	☐ PRN
Acetaminophen:	☐ PO	☐ IV	☐ 25mg	☐ 50mg	☐ Pre-med	☐ PRN

Center will use Hypersensitivity protocol established by Infusion for Health and P.I.

ACTEMRA DOSAGE

Date of Last Treatment, if Continuation: _____

Maximum Dose is 800mg Route: ☑ IV

☐ 4 mg/kg ☐ 8 mg/kg Every ☐ 4 weeks OR ☐ 2 weeks Total Dose: _____ mg

Start Date of Infusion: _____

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

Lab Orders: ☐ List: _____

☐ Prior to first appointment ☐ Other Frequency: _____

☐ Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

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