

## ACTEMRA ORDER FORM

PLEASE EMAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO REFERRALS@WELLSINFUSION.COM. YOU CAN ALSO FAX IT TO 1-570-9INFUSE (1-570-946-3873)

Preferred Location: \_\_\_\_\_

### Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Height (in): \_\_\_\_\_ Weight (lb): \_\_\_\_\_ Referral Status:  New  Updated  Renewal

### Infusion/ Injection Information

Primary ICD-10 Code: \_\_\_\_\_ Primary ICD-10 Description: \_\_\_\_\_

Other ICD-10 Codes: \_\_\_\_\_ Other ICD-10 Descriptions: \_\_\_\_\_

#### Actemra (Tocilizumab) Dosing Info:

- Initial Dosing, \_\_\_\_\_ mg/kg IV
- Maintenance Dosing, \_\_\_\_\_ mg/kg IV Every 4 Weeks

#### Required Documentation:

- Full Patient Chart
- Insurance Cards (Front and Back)
- Clinical Notes Supporting Diagnosis
- List of Current Medications, Conditions, and Allergies
- CBC and CMP
- HepB Surf AG (within 12 mo)
- TB Results (within 6 mo)

#### Premedications:

- Acetaminophen \_\_\_\_\_ mg  
 PO  IV
- Cetirizine \_\_\_\_\_ mg  PO
- Diphenhydramine \_\_\_\_\_ mg  
 PO  IV
- Hydrocortisone \_\_\_\_\_ mg  IV
- Loratadine \_\_\_\_\_ mg  PO
- Methylprednisolone \_\_\_\_\_ mg  IV
- Other: \_\_\_\_\_ mg  
 PO  IV

### Ordering Provider Information

Practice Name: \_\_\_\_\_ Practice Phone: \_\_\_\_\_ Practice Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ Referral Coordinator Name: \_\_\_\_\_

Referral Coordinator Email: \_\_\_\_\_ Referral Coordinator Phone: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_ Specialty: \_\_\_\_\_

All Injections, Infusions, and Rescue Management for Reactions will be handled in accordance with Wells Infusion's Protocols. Orders are valid for 1 year unless stated otherwise.

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date