ACTEMRA® Infusion Referral Form

University Hospitals
Home Care Services

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Warrensville Heights, OH 44128
Phone: 800-552-8442
Fax: 216-201-5127

Please complete each section of the referral form below and fax along with a copy (front and back) of all of the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Info.

Prescriber: ______________________ **NPI:** ______________________

Phone: ______________ **Fax:** ______________ **Office Contact:** ______________

Address: ____

Patient Information

Name: ______________________ **DOB:** ______________ ☐**M** ☐**F**

Address: ____

Phone: ______________ **2nd Phone:** ______________ **SSN:** ______________

Primary Language: ______________ **Functional Limitations:** ______________

Clinical Information

Diagnosis (Include ICD-10 Code): ______________________________

Weight:______________ ☐lb ☐kg **Height:**______________ ☐in **IV access:** ☐PIV ☐PICC ☐Port ☐Other: ______________

Patient's first dose of IV Actemra? ☐Yes ☐No (If no, date of last dose: ______________ Prior dose (in mg): ______________)

Allergies:______________________________ **Latex allergy?** ☐Yes ☐No

Prior treatments/Reason for discontinuation:______________________________

____

Date of *negative* TB test: ____________ ☐TB test pending, will fax results. **Patient is HBV negative or has been treated:** ☐Yes ☐No

History of kidney disease: ☐Yes ☐No If yes, SCr: _______ GFR/CrCl: ________ **History of heart failure:** ☐Yes ☐No

Required Labs:	ANC	Platelets	AST	ALT	SCr
Result:			Result: __________ Upper limit of normal: __________	Result: __________ Upper limit of normal: __________	
Date:					

Referring provider's preferred site of care: ☐OptiMed Infusion Center ☐Home Infusion ☐OptiMed to determine site of care
Site of care preference is subject to payer limitations, clinical appropriateness, and the availability of servicing providers.

Prescription Information

Based on the clinical judgement of the pharmacist, doses may be rounded up or down by no more than 10% unless checked here: ☐

Actemra® Dose	Infusion Diluent/Volume	Rate	Frequency	Number of Doses
Adult Rheumatoid Arthritis* ☐4mg/kg ☐8mg/kg	in 100mL NaCl 0.9%	Infused over 60 minutes	every four weeks	__________
Polyarticular JIA ☐10mg/kg (weight <30kg) ☐8mg/kg (weight ≥30kg)	Weight <30kg: in 50mL NaCl 0.9% Weight ≥30kg: in 100mL NaCl 0.9%	Infused over 60 minutes	every four weeks	__________
Systemic JIA ☐12mg/kg (weight <30kg) ☐8mg/kg (weight ≥30kg)	Weight <30kg: in 50mL NaCl 0.9% Weight ≥30kg: in 100mL NaCl 0.9%	Infused over 60 minutes	every two weeks	__________

*Doses exceeding 800mg per infusion are not recommended.

Premedication/PRN medication orders:______________________________

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Laboratory orders: ☐ANC/Platelets/AST/ALT 4 to 8 weeks after the start of therapy and every 3 months thereafter.

Other lab orders (subject to availability): ______________________________

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

Signature: ______________________________ **Date:** ______________

V.03.21.18.A

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