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:** _____ **MRN:** _____

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: ☐Home Care Infusion Center ☐Home Infusion ☐Home Care 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:_____

_____

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 Home Care 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:** _____