Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Actemra® (tocilizumab) Standard Plan of Treatment for Rheumatology

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:			
Patient Name:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	M05.____ - Rheumatoid Arthritis with Rheumatoid factor	☐	M31.6 - Other Giant Cell Arteritis
☐	M06.____ - Rheumatoid Arthritis without Rheumatoid factor	☐	M31.5 - Giant cell Arthritis with Polymyalgia Rheumatica
☐	_____- Other:		

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list / Tried and failed therapies		NEXT INFUSION DATE:
4	**REQUIRED:**TB screening for new start patients		**IF ORDER CHANGE:**
5	HBV screening/labs as required by payor		☐ **Continue current order until insurance approved**
6	Recent CBC with diff and LFTs		

MEDICATION ORDERS:

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

NOTE: Patient may be ineligible to receive tocilizumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, new-onset abdominal symptoms, and/or surgery.

IV	Diphenhydramine	◯	25mg	◯	50mg				
	Methylprednisolone	◯	40mg	◯	125mg	◯	Other:		
	Famotidine	◯	20mg	◯	40 mg				
	Other:	◯							

PO	Acetaminophen	◯	325mg	◯	500mg	◯	650mg	◯	1000mg
	Famotidine	◯	20mg	◯	40mg				
	Diphenhydramine	◯	25mg	◯	50mg				
	Fexofenadine	◯	60mg	◯	180mg				
	Cetirizine	◯	10mg						
	Loratadine	◯	10mg						
	Other:	◯							

MEDICATION:

☑ Actemra® (tocilizumab) in 100ml NS given IV over 1 hour or greater as tolerated.

DOSE: Rheumatoid Arthritis

◯ 4mg/kg in 100mL NS every 4 weeks

◯ 8mg/kg in 100mL NS every 4 weeks

DOSE: Giant Cell Arthritis

◯ 6mg/kg in 100mL NS every 4 weeks

SPECIAL/LAB ORDERS:

◯ _____

_____

Prescriber confirms that the patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment. Prescriber to monitor patient for symptoms of HBV and TB infection and reactivation as clinically appropriate.

LAB ORDERS:

CBC with diff, platelets, ALT and AST prior to first dose, at 2nd infusion, and then every 12 weeks.

LAB PARAMETERS: (Pharmacist to perform clinical lab monitoring)

On Initiation: ANC > 2000mm^3; AST/ALT < 1.5 x ULN

Maintenance: **If ANC** is 500 to 1000 cells/mm^3, hold dose and notify referring MD. When ANC >1000 cells/mm^3 therapy may be resumed. If ANC < 500 cells/mm^3, then discontinue and notify referring MD. **If Platelet count** 50,000 to 100,000 cells/mm^3, hold dose. When platelet count is > 100,000 cells/mm^3, therapy may be resumed. If Platelet count is <50,000 cells/mm^3, then discontinue and notify referring MD. **If AST/ALT** are > 3 5 x upper limit normal HOLD dose and notify referring MD

ACTEMRA® doses exceeding 800 mg are not recommended.

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	

Palmetto
INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com

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