

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Actemra® (tocilizumab) Pediatric – (over 2 years of age) Standard Plan of Treatment

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)

M08.2 - Juvenile Rheumatoid Arthritis with Systemic Onset
M08.3 - Juvenile Rheumatoid Polyarthritis (seronegative)
- Other:

REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list / Tried and failed therapies	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	TB screening	FROM PREVIOUS	IF ORDER CHANGE: Continue current order until insurance approved
5	HBV screening/labs as required by payor	THERAPY:	
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		PO	Acetaminophen	325mg	500mg	160mg/5ml	mls
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg	12.5mg/5ml:	mls
	Other:					Loratadine	10mg			
					Other:					

MEDICATION:

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

DOSE: for Polyarticular JIA every 4 weeks (No < 28 days)

<input type="checkbox"/>	Less than 30 kg weight – 10mg/kg in 50ml NS
<input type="checkbox"/>	30 kg or greater – 8mg/kg in 100ml NS

DOSE: for Systemic JIA every 2 weeks (No < 14 days)

<input type="checkbox"/>	Less than 30 kg weight – 12mg/kg in 50ml NS
<input type="checkbox"/>	30 kg or above weight – 8mg/kg in 100ml NS

SPECIAL ORDERS:

<input type="checkbox"/>	
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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 infection and reactivation as clinically appropriate.

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

<input checked="" type="checkbox"/>	Start PIV/Access CVC
<input checked="" type="checkbox"/>	Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX 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



Checklist for referrals to AccuRX Infusion:

Fax referral to 1.866.990.3192

- 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. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com