AYSA
THERAPEUTICS INFUSION CENTER

ACTEMRA (TOCILIZUMAB) ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

J Code: J3262 Diagnosis: ☐ Rheumatoid Arthritis ICD-10 Code: _____

☐ Other: _____ ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Date of Last TB/CXR: _____ ☐ Copy of documentation attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

☐ TB and Hepatitis B Documentation attached

Hepatitis B Protocol: Hep B surface antigen and Heb B Core AB total required

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD ☐ Yearly TB Screening (*optional*)

ACTEMRA ORDERS

Actemra
- ☐ 4mg/kg IV every 4 weeks for _____ doses, then followed by 8 mg/kg IV every 4 weeks thereafter
- ☐ 4mg/kg IV every 4 weeks
- ☐ 8mg/kg IV every 4 weeks
- ☐ Other dose: _____ mg IV every 4 weeks

DOSE NOT TO EXCEED 800MG IN RA DIAGNOSIS

Protocol: Labs per diagnosis as follows:

All dx: Obtain CBC w/ diff, LFTs, and Lipid Panel prior to 1st infusion

RA: CBC w/ diff, LFTs, and Lipid Panel prior to 3rd infusion
All subsequent infusions - CBC w/ diff q 3 mos, LFTs q 4-8 weeks for 1st 6 mos, then q 3 mos, and Lipid Panel q 6 mos

PJIA: CBC w/ diff, LFTs, and Lipid Panel prior to 2nd dose, then CBC w/ diff, LFTs q 4-8 weeks and Lipid Panel q 6 months

SJIA: CBC w/ diff, LFTs, and Lipid Panel prior to 2nd dose, then CBC w/ diff, LFTs q 2-4 weeks and Lipid Panel q 6 months

Additional Orders / Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc*. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____

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