



# ACTEMRA (TOCILIZUMAB) INFUSION ORDERS

**P:** 877.365.5566 | **F:** 855.889.2946

**PATIENT INFORMATION:** Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

**Patient Status:**  New to Therapy  Continuing Therapy **Next Treatment Date:** \_\_\_\_\_

**MEDICAL INFORMATION**

**Diagnosis:**  Rheumatoid Arthritis  Juvenile Rheumatoid Arthritis  Ankylosing Spondylitis  
 Acute Graft Versus Host Disease  Giant Cell Arteritis  CRS  
 Other: \_\_\_\_\_

**ICD-10 Code:** \_\_\_\_\_

Patient Weight: \_\_\_\_\_ lbs.(required) Allergies: \_\_\_\_\_

**THERAPY ORDER**

**Actemra Orders:**

- 4mg/kg IV every 4 weeks for \_\_\_\_\_ doses, followed by 8 mg/kg IV every 4 weeks thereafter x 1 year
- 4mg/kg IV every 4 weeks x 1 year
- 8mg/kg IV every 4 weeks x 1 year **\*\*\*DOSE NOT TO EXCEED 800MG IN RA DIAGNOSIS\*\*\***
- Other dose: \_\_\_\_\_ mg IV every 4 weeks x 1 year
- Other: \_\_\_\_\_

**Lab Protocol:**

**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 Lab Orders:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

TB QFT Screening yearly (optional)

Required labs to be drawn by:  Paragon  Referring Provider

**PROVIDER INFORMATION**

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Opt out of Paragon selecting site of care (if checked, please list site of care): \_\_\_\_\_

**SERVICE AREAS**

City: \_\_\_\_\_ State: \_\_\_\_\_

*View our locations here:*



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**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL**

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - Rheum - Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)?  Yes  No  
If yes, which drug(s)? \_\_\_\_\_
  - Rheum - Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Simponi, Xeljanz, infliximab)?  Yes  No  
If yes, which drug(s)? \_\_\_\_\_
  - CRS dx - Has the patient received treatment with a chimeric antigen receptor T cell therapy (i.e., Kymriah, Yescarta) or Blincyto?  Yes  No If yes, which drug(s)? \_\_\_\_\_
- Include labs and/or test results to support diagnosis
  - Rheumatoid Factor or anti-CCP (attach results)
  - Temporal artery biopsy or cross-sectional imaging or acute-phase reactant elevation (GCA dx)
- If applicable* - Last known biological therapy: \_\_\_\_\_ and last date received: \_\_\_\_\_.  
If patient is switching to biologic therapies, please perform a wash-out period of \_\_\_\_\_ weeks prior to starting Actemra.
- Other medical necessity: \_\_\_\_\_

**REQUIRED PRE-SCREENING**

- TB screening test completed within 12 months - attach results**
  - Positive  Negative
- Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) - attach results**
  - Positive  Negative
- CBC w/diff, LFTs, Lipid Panel - attach results**

\*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

**Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance**

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