PARAGON HEALTHCARE

A Carelon Company

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

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:			Email:
Address:		City:	State: ZIP:
NPI #:	DEA#:		Tax ID:

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing		Refills
Actemra (tocilizumab)	☐ 4mg/kg IV every 4 weeks for _____ doses, followed by 8 mg/kg IV every 4 weeks thereafter ☐ 4mg/kg IV every 4 weeks ☐ 8mg/kg IV every 4 weeks ☐ _____ mg IV every 4 weeks ☐ Other: _____	***DOSE NOT TO EXCEED 600MG IN GCA DX** ***DOSE NOT TO EXCEED 800MG IN RA/CRS DX**	☐ x 1 year ☐ _____

Lab Protocol:

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

RA/GCA: CBC w/diff, LFTs, & Lipid Panel prior to 3rd infusion

All subsequent infusions - CBC w/diff q 3 months; LFTs q 4-8 weeks for 1st 6 months, then q 3 months

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

SJIA: CBC w/diff & LFTs prior to 2nd dose; Lipid Panel between 4-8 weeks; then CBC w/diff & LFTs q 2-4 weeks

Additional Lab Orders: _____ Frequency: _____

☐ TB QFT Screening yearly (optional) ☐ Baseline HepBcAB total

Required labs to be drawn by: ☐ Paragon ☐ Referring Provider

Other orders: _____

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

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.

Prescriber Signature: X **Date:**

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COMPREHENSIVE SUPPORT FOR ACTEMRA (TOCILIZUMAB) THERAPY

PATIENT INFORMATION

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 if a new start) - attach results**
☐ **Positive** ☐ **Negative**

☐ **Hepatitis B screening test completed (Hepatitis B surface antigen) - 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+)