FLOMED INFUSION

6274 Linton Blvd. Suite 105 | Delray Beach, FL 33484
T: 561-559-9800 F: 561-559-9801
flomedinfusion.com

ACTEMRA (tocilizumab)

PATIENT INFORMATION

Patient Name:_____ Date of Birth: _____ Phone: _____
Status: ☐ New to therapy ☐ Continuing ☐ Next Due Date (if applicable)

PROVIDER INFORMATION

Provider Name:_____ Provider NPI: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

Practice Name: _____

Practice Phone: _____ Fax: _____ Contact Person: _____

MEDICAL INFORMATION

Patient Weight: _____ Patient Height: _____ ICD-10 Code (required): _____ ICD-10 Description: _____

Known Allergies: _____

Required Labs: TB baseline testing Quantiferon Gold or PDD, and Hep B surface antigen and Hep B Core AB total

DETAILS NEEDED FOR AUTHORIZATION

- Proof of patient being concurrently treated with any other biologic: _____
- **All dx:** Obtain CBC w/diff, LFTs, and Lipid Panel prior to first infusion. **RA dx:** CBC w/diff LFTs, and Lipid Panel prior to third infusion. All infusions thereafter: CBC w/diff q 3 mos, LFTs q 4-8 weeks for first 6 mos, then q 3 mos, and Lipid Panel q 6 mos. **PJIA dx:** 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 mos. **SJIA dx:** 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 mos.

ACTEMRA (tocilizumab) ORDERS

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

Additional Orders/Comments: _____

_____

_____

_____

ADULT RESCUE MANAGEMENT PROTOCOL

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Following standing reaction orders, including diphenhydramine, methylprednisolone, albuterol, and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

REQUIRED STANDARD DOCUMENTATION NEEDED

- Patient demographics
- Patient medical insurance card, copied front and back
- Patient pharmacy card, copied front and back (if they have one)
- Most recent chart notes and if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

PROVIDER AUTHORIZATION

Provider's Signature: _____ Print Name: _____ Date: _____