Actemra Order Form

Pre-filled order form for Actemra (tocilizumab) — IL-6 inhibitor for inflammatory arthritis

REFERRING PROVIDER

PROVIDER NAME	NPI	DEA (IF CONTROLLED)	SPECIALTY

PRACTICE / CLINIC NAME	OFFICE PHONE	OFFICE FAX

OFFICE CONTACT NAME	CONTACT PHONE	CONTACT EMAIL

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH	SEX	PATIENT PHONE	BEST TIME TO CONTACT

ADDRESS	CITY, STATE, ZIP

INSURANCE

PRIMARY INSURANCE	MEMBER ID	GROUP #

SECONDARY INSURANCE (IF ANY)	MEMBER ID	GROUP #

DIAGNOSIS & CLINICAL JUSTIFICATION

PRIMARY DIAGNOSIS	ICD-10 CODE

SECONDARY DIAGNOSIS (IF APPLICABLE)	ICD-10 CODE

Common indications for this medication: *Rheumatoid arthritis (moderate to severe), Giant cell arteritis, Systemic juvenile idiopathic arthritis, Polyarticular juvenile idiopathic arthritis, Cytokine release syndrome*

BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY

PRIOR THERAPIES TRIED AND OUTCOME

ACTEMRA REFERENCE

Generic name: tocilizumab

Specialty: Rheumatology

Typical infusion time: About 1 hour

Typical schedule: Every 4 weeks

Biosimilars / brands: Tofidence, Tyenne

MEDICATION ORDER

MEDICATION (DEFAULT: ACTEMRA) **GENERIC / ALT (TOCILIZUMAB)** **STRENGTH / FORMULATION**

DOSE **FREQUENCY (TYPICAL: EVERY 4 WEEKS)** **DURATION (TYPICAL: ABOUT 1 HOUR)**

ROUTE **PRE-MEDICATIONS (IF ANY)** **SPECIAL INSTRUCTIONS**

ANTICIPATED START DATE **# OF DOSES AUTHORIZED** **SUBSTITUTION ALLOWED (Y/N)** **BIOSIMILAR ACCEPTABLE (Y/N)**

REQUIRED LABS & MONITORING

Check all labs the prescriber requires Arbor to verify before each infusion:

- ☐ CBC w/ differential
- ☐ CMP
- ☐ Liver function panel
- ☐ Hepatitis B/C panel
- ☐ TB screen (T-SPOT or QFT)
- ☐ Pregnancy test (urine)
- ☐ Iron studies (ferritin, TSAT)
- ☐ Vitamin levels (B12, D, folate)
- ☐ Other (specify below)

OTHER LABS / MONITORING REQUIREMENTS

PRESCRIBER SIGNATURE

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Arbor Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

PRESCRIBER SIGNATURE **PRINTED NAME** **DATE**

Form code: ARB-ORDER-ACTEMRA · Submit to Arbor Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Arbor will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@arborinfuse.com