ACTEMRA® Infusion

OptiMed
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Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber: ______________________ **NPI:** ______________________

Phone: ______________ **Fax:** ______________ **Office Contact:** ______________________

Address: ____

Patient Information

Name: ______________________ **DOB:** ______________________ ☐**M** ☐**F**

Address: ____

Phone: ______________ **2nd Phone:** ______________ **SSN:** ______________

Primary Language: ______________ **Functional Limitations:** ______________________

Clinical Information

Diagnosis (include ICD-10 code): ____

Weight: __________ ☐lb ☐kg **Height:** __________ ☐in **IV access:** ☐PIV ☐PICC ☐Port ☐Other: ______________

Patient's first dose of IV ACTEMRA®? ☐Yes ☐No; date of last dose ______________; prior dose (in mg) ______________

Allergies: ______________________________________ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: ____

____

Date of *negative* TB test: __________ or ☐TB test pending, will fax results. **Patient is HBV negative or has been treated:** ☐Yes ☐No

History of kidney disease: ☐Yes ☐No If yes, SCr: __________ GFR/CrCl: __________ **History of heart failure:** ☐Yes ☐No

Required Labs:	ANC	Platelets	AST	ALT	SCr	LDL	HDL	TG	Total Chol
Result:			Result: ________ (ULN: ________)	Result: ________ (ULN: ________)					
Date:									

Referring provider's preferred site of care*: ☐OptiMed Infusion Center ☐Home Infusion* ☐OptiMed to determine site of care
*Site of care preference is subject to payer limitations, clinical appropriateness, and the availability of servicing providers.

Prescription Information

Based on the clinical judgement of the pharmacist, doses may be rounded up or down by no more than 10% unless checked here: ☐

ACTEMRA® Dose	Infusion Diluent/Volume	Rate	Frequency	Number of Doses
Adult Rheumatoid Arthritis* ☐4mg/kg ☐8mg/kg	in 100mL NaCl 0.9%	Infused over 60 minutes	every four weeks	________
Polyarticular JIA ☐10mg/kg (weight <30kg) ☐8mg/kg (weight ≥30kg)	Weight <30kg: in 50mL NaCl 0.9% Weight ≥30kg: in 100mL NaCl 0.9%	Infused over 60 minutes	every four weeks	________
Systemic JIA ☐12mg/kg (weight <30kg) ☐8mg/kg (weight ≥30kg)	Weight <30kg: in 50mL NaCl 0.9% Weight ≥30kg: in 100mL NaCl 0.9%	Infused over 60 minutes	every two weeks	________

*Doses exceeding 800mg per infusion are not recommended.

Premedication orders: ____

PRN medication orders: ____

Laboratory orders: ☐ANC/ Platelets/ AST/ ALT eight (8) weeks after the start of therapy and every three (3) months thereafter.
☐Lipid panel (total cholesterol, LDL, HDL, triglycerides) eight (8) weeks after the start of therapy.

Other lab orders (subject to availability): ____

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.

Signature: ______________________________ **Date:** ______________________

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