



Actemra Order Form

Select patient referral location: Akron Blue Ash Cleveland Columbus Crestview Hills Springfield West Cincinnati
 Other _____

Fax completed form to 888-977-0914. For new referrals, please **include recent labs and last two office visit notes.**

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

| | |
|---|--|
| Name: | DOB: |
| Home phone: | Other phone: |
| Email: | |
| Social Security #: | Allergies: |
| Gender: <input type="checkbox"/> M <input type="checkbox"/> F | Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg |
| Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable): | |

2. PHYSICIAN INFORMATION

| | |
|------------------------|-------------------|
| Physician's name: | NPI#: |
| License #: _____ TIN#: | DEA#: |
| Address: | |
| City: | State: _____ Zip: |
| Office contact: | Email: |
| Office phone: | Office fax: |

3. DIAGNOSIS INFORMATION (and year of diagnosis)

Rheumatoid Arthritis (_____) Polyarticular Juvenile Idiopathic Arthritis (_____) Other (specify): _____
 Systemic Juvenile Idiopathic Arthritis (_____) ICD 10 (_____)

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

| | |
|--|---|
| <p>ACTEMRA</p> <p><input type="checkbox"/> Administer ____mg/kg IV every ____weeks</p> <p><input type="checkbox"/> Vital signs per HI Protocol</p> <p><input type="checkbox"/> Anaphylaxis & Hydration Management per HI Protocol</p> | <p>PRE-MEDICATIONS <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO</p> <p><input type="checkbox"/> Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)</p> <p><input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> PO <input type="checkbox"/> IV (requires driver)</p> <p><input type="checkbox"/> Methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg <input type="checkbox"/> 80mg <input type="checkbox"/> 125mg IV</p> <p><input type="checkbox"/> Prednisone _____ mg PO</p> <p><input type="checkbox"/> Other: _____</p> <p>POST-MEDICATIONS <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO</p> <p><input type="checkbox"/> Prednisone _____ mg PO</p> <p><input type="checkbox"/> Other: _____</p> |
|--|---|

6. LABS

| | | |
|--|--|---|
| <input type="checkbox"/> CBC w/Diff | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> CRP | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> CMP | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> ESR | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Hepatic Panel | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Renal Panel | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): _____ | | |
| <input type="checkbox"/> Other (specify): _____ | | |

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE DATE