



Please fax completed form, insurance card, and clinical documentation to:
FAX: (334)284-3107

ACTEMRA ORDER

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Allergies: _____		
Height: _____ Weight: _____		

Indication:

MO5. __ Rheumatoid Arthritis
 MO6. __ Rheumatoid Arthritis w/o rheumatoid factor
 M31. __ Giant Cell Arteritis
 Other _____

DRUG:

4mg/kg IV every 4 weeks
 4mg/kg IV X 1 infusion then increase to 8mg/kg every 4 weeks
 6mg/kg IV every 4 weeks
 8mg/kg IV every 4 weeks
 Other _____

PREMEDICATION ORDERS: *Not required by PI*

Acetaminophen po: 1000mg 500mg 30 min prior to infusion.
 Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.
 Solu-Medrol: 62.5mg IVP 100mg IVP Other _____ 30 min prior to infusion.
 Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
 - Insurance card(s) – copy of front & back
 - Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
- Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP Lipids TB Hep B Other: _____