

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 Ascribe 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. Ascribe 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 Ascribe Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Ascribe Infusion will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@ascribeinfusion.com