Actemra Enrollment Form

Date: ____________________

Patient Name: ____________________

Date of Birth: ____________________

TwelveStone Health Partners
Fax Referral To:
(800) 223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

PREVIOUS ADMINISTRATION

If YES, please provide the following information:

Last Infusion Date: ____________________

Next Infusion Date: ____________________

If NO, please indicate desired location for first dose:

☐ Physician's Office

TwelveStone Infusion Center:

☐Canton ☐Chattanooga ☐Knoxville ☐Mount Juliet ☐Murfreesboro

☐ Other: ____________________

Desired Start Date: ____________________

DIAGNOSIS

Description	*ICD-10 Code*
☐ Rheumatoid Arthritis	☐ M06.09 ☐ Other:_________

OTHER REQUIRED DOCUMENTATION *(Please attach documents)*

☐ This signed order form

☐ History and Physical

☐ Patient Demographics and Insurance Information

☐ Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION *(Please attach all clinical information, lab results and other medical history documents)*

Patient Weight: :________Kg Height: _________Inches/CM BSA :______________ Allergies: ____________________

Line Access: ☐ PIV ☐ PICC (SL DL TL) ☐ PORT (Huber size________Gauge_____Length) ☐ Sub-Q

MEDICATION	DOSE	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (Check below for TwelveStone to Draw)
☐ Actemra	20mg/ml Vial	☐ Initiation - Infuse _____ mg IV over 60 minutes every ____ weeks ☐ Maintenance - Infuse _____mg IV over 60 minutes every _____ weeks		☐ CBC w/Differential ☐ Liver Function Panel ☐ TB QuantiFERON Gold

LAB ORDERS - (To be drawn by TwelveStone)

Order	Frequency
CBC w/Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
CBC w/o Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
CMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
BMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
CRP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Sed Rate	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Calcium	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Tb QuantiFERON Gold	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Hepatitis Panel	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Other________________________________	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________

PRE-MEDICATIONS - *RECOMMENDED/Check Here if NO Pre-Meds _____

Oral	IV
*Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg	Dexamethasone: ☐ 10mg
Cetirizine: ☐ 10mg	*Diphenhydramine: ☐ 25mg ☐ 50mg
Diphenhydramine: ☐ 25mg ☐ 50mg	Famotidine: ☐ 20mg ☐ 40mg
Famotidine: ☐ 20mg ☐ 40mg	Methylprednisolone: ☐ _____mg IV over ______ mins
Ibuprofen: ☐ 200mg	Ondansetron: ☐ 4mg ☐ 8mg
Loratadine: ☐ 10mg	
Ondansetron: ☐ 4mg	

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone # ____________ Physician's NPI# ____________ Physician's Fax # ____________ Physician's Address ____________

Dispense as Written ____________ Date ____________ Substitution Allowed ____________ Date ____________

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 615-895-0186 or faxing back to the originator.