

TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012



ACTEMRA ORDER FORM

Date: _____	ICD-10 Code: _____	<p style="text-align: center;">Therapy Status</p> <input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____
Patient Name: _____	Allergies: _____	
Date of Birth: _____	Weight: _____ lbs OR _____ kg	

Provider Information

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

MEDICATION ORDER

Actemra	<input type="checkbox"/> Actemra _____ mg/kg IV every _____ weeks to be given over one our per protocol. <input type="checkbox"/> Actemra 162mg SQ to be given weekly per protocol.	Refills x one year from date of signature unless indicated below. <input type="checkbox"/> _____ Refills	<p>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</p> <input checked="" type="checkbox"/> TB Quant Gold within the past 12 months <input checked="" type="checkbox"/> Hepatitis B Surface Antigen <input checked="" type="checkbox"/> Hepatitis B Core Antibody <input checked="" type="checkbox"/> Absolute Neutrophil Count, Platelet Count, and ALT/AST within the past 60 days
---------	--	---	--

PRE-MEDICATIONS

<p>Oral</p> <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<p>IV</p> <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
--	---

<p>LAB ORDERS (please indicate any labs to be drawn and frequency)</p> <p><small>**Surveillance lab ordering and monitoring is the responsibility of the prescriber**</small></p>	<p>(Please fax this signed order form, along with the following documents to 800-223-4063)</p> <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
---	---

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

Dispense as Written: _____ Prescriber Name	Substitution Allowed: _____ Prescriber Name
_____ Date	_____ Date