

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: _____	Therapy Status <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 Therapeutic interchange to insurance preferred biosimilar (Tyenne) authorized unless otherwise specified below: <input type="checkbox"/> Do not use biosimilar	<input type="checkbox"/> Actemra _____ mg/kg IV every _____ weeks to be given over one hour. <input type="checkbox"/> (<100kg) Actemra 162mg SQ to be given everyother week. <input type="checkbox"/> (≥100kg) Actemra 162mg SQ to be given weekly.	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> <ul style="list-style-type: none"> ✓ TB Quant Gold within the past 12 months ✓ Hepatitis B Surface Antigen ✓ Absolute Neutrophil Count, Platelet Count, and ALT/AST within the past 60days
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PRE-MEDICATIONS

Oral <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: _____	IV <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: _____
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LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
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By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

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