

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com



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

<p>Actemra</p> <p>Therapeutic interchange to insurance preferred biosimilar (Tyenne) authorized unless otherwise specified below:</p> <p><input type="checkbox"/> Do not use biosimilar</p>	<p><input type="checkbox"/> Actemra _____ mg/kg IV every _____ weeks to be given over one hour per protocol.</p> <p><input type="checkbox"/> (<100kg) Actemra 162mg SQ to be given weekly per protocol.</p> <p><input type="checkbox"/> (>100kg) Actemra 162mg SQ to be given every other week.</p>	<p>Refills for one year from date of signature unless indicated below.</p> <p>_____ Refills</p>	<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> <p>✓ TB Quant Gold within the past 12 months</p> <p>✓ Hepatitis B Surface Antigen</p> <p>✓ Absolute Neutrophil Count, Platelet Count, and ALT/AST within the past 60days</p>
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PRE-MEDICATIONS

<p>Oral</p> <p><input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg</p> <p><input type="checkbox"/> Loratadine: 10mg</p> <p><input type="checkbox"/> Cetirizine: 10mg</p> <p><input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg</p> <p><input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg</p> <p><input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg</p> <p><input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg</p> <p><input type="checkbox"/> Other: _____</p>	<p>IV</p> <p><input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg</p> <p><input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg</p> <p><input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg</p> <p><input type="checkbox"/> Methylprednisolone: 125mg</p> <p><input type="checkbox"/> Hydrocortisone: 100mg</p> <p><input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg</p> <p><input type="checkbox"/> Other: _____</p>
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LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

<p>**Surveillance lab ordering and monitoring is the responsibility of the prescriber**</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
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By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

<p>Dispense as Written: _____</p>	<p>Substitution Allowed: _____</p>
<p>_____ Prescriber Signature</p>	<p>_____ Prescriber Signature</p>
<p>_____ Date</p>	<p>_____ Date</p>