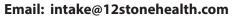
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

**Direct Phone: (844) 893-0012** 





ACTEMRA ORDER FORM					
Date: ICD-10 Code:				Therapy Status	
Patient Name: Allergies:			☐ New Start		
Date of Birth:	Weight:Ibs OR	kg	☐ Conti	Continuing Therapy:  Last Dose:	
PROVIDER INFORMATION					
Ordering Provider: Provider Fax:					
Provider NPI: Pro			Provider Address:		
Provider Phone:					
MEDICATION ORDER					
Actemra  Therapeutic interchange to insurance preferred biosimilar (Tyenne) authorized unless otherwise specified below:  Do not use biosimilar	□ Actemra mg/kg IV every weeks to be given over one hour per protocol. □ (<100kg) Actemra 162mg SQ to be given weekly per protocol. □ (>100kg) Actemra 162mg SQ to be given every other week.	Refills for one year from date of signature unless indicated below. Refills		Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:  V Negative TB result and date:, Hepatitis B Surface Antigen.	
PRE-MEDICATIONS					
Oral         □ Acetaminophen:325mg500mg650mg         □ Loratadine: 10mg         □ Cetirizine: 10mg         □ Diphenhydramine:25mg50mg         □ Famotidine:20mg40mg         □ Ibuprofen:200mg400mg600mg         □ Ondansetron:4mg8mg         □ Other:		☐ Diphenhyd ☐ Famotidin ☐ Methylpre ☐ Hydrocort ☐ Ondanset ☐ Other:	□ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg □ Ondansetron:4mg8mg □ Other:		
LAB ORDERS (please indicate any labs to be drawn and frequency)			OTHER REQUIRED DOCUMENTATION		
**Surveillance lab ordering and monitoring is the responsibility of the prescriber**  By signing below, I certify that the above therapy is med By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as m to payors with respect to this patient and prescription order. This enrollmen Dispense as Written:		to 800-223-406     History & Phy     Patient Demo     Medication Li     Recent Lab W      ledically necessary.     s my designated agent in ment form shall serve as	lically necessary. Prescriber's Signature (SIGN BELOW) by designated agent in submitting prior authorizations and other clinically required information		
Prescriber Signature	escriber Signature Date Prescriber Signature		nature	 Date	