

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____ Please fax a copy of front and back of the insurance card(s).	Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis: <input type="checkbox"/> M06.9 (Rheumatoid Arthritis) <input type="checkbox"/> M08.0 (Juvenile Idiopathic Arthritis) <input type="checkbox"/> Other: _____			
Prior Therapy	Yes	No	Reason for Discontinuation of Therapy
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Comorbidities: _____ Concomitant Medications: _____ Allergies: _____			

SQ ACTEMRA			
Prescription	Directions	Quantity	Refills
<input type="checkbox"/> Actemra 162mg/0.9 ml PFS	Inject 162 mg subcutaneously once weekly	4 x 162mg	_____
<input type="checkbox"/> Actemra 162mg/0.9 ml PFS	Inject 162 mg subcutaneously every other week	2 x 162mg	_____

IV ACTEMRA
Flushing Orders: • Per HPS protocol PIV: 0.9% Sodium Chloride 3-20 ml before and after infusion as needed Port : Bacteriostatic 0.9% Sodium Chloride 3-20ml into port at time of access or at least monthly, 0.9% Sodium Chloride 3-20 ml before and after infusion and as needed, Heparin 100units/ml 5ml as lock after infusion Pre-Medication Orders: • No routine pre-medication necessary. Orders will be obtained if patient has reaction and requires pre-medications for subsequent doses. <input type="checkbox"/> Other: _____ ACTEMRA® (tocilizumab): Frequency: every 4 weeks Dose: RPh will round up to the nearest combination of vial size (80mg, 200mg, 400mg) or <input type="checkbox"/> Give exact dose (do NOT round) <input type="checkbox"/> 4mg/kg IV over at least 1 hour <input type="checkbox"/> 8mg/kg IV over at least 1 hour <input type="checkbox"/> Other _____ IV over 1 hour ** maximum of 800 mg per dose** • Dilute in 100ml 0.9% Sodium Chloride for children >30 kg and adults Duration: <input type="checkbox"/> Refills x 1 year OR <input type="checkbox"/> _____ infusions LABS: every _____ (frequency) <input type="checkbox"/> CBC with Diff <input type="checkbox"/> AST/ALT <input type="checkbox"/> Other: _____ NOTE: • Orders are initiated unless crossed out by provider

Prescriber's Signature: _____	_____ Substitution Permitted	_____ Dispense as Written	Date: _____
I authorize Home Parenteral Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Home Parenteral Services.			

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