HOME PARENTERAL SERVICES

ACTEMRA®
(tocilizumab):

PHONE: 1-800-637-9201
FAX: 1-417-269-0692

Patient Information

Patient name: _____ DOB: _____
Sex: ❑ Female ❑ Male SSN: _____
Language: _____ Wt: _____ ❑kg ❑lbs Ht: _____ ❑cm ❑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 + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ❑ First Fill ❑ Always Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ M06.9 (Rheumatoid Arthritis) ❑ M08.0 (Juvenille Idiopathic Arthritis)
❑ Other:_____

Prior Therapy Yes No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comorbidities: _____
Concomitant Medications: _____
Allergies: _____

SQ ACTEMRA

Prescription	Directions	Quantity	Refills
❑ Actemra 162mg/0.9 ml PFS	Inject 162 mg subcutaneously once weekly	4 x 162mg	_____
❑ 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.
❑ Other:_____

ACTEMRA® (tocilizumab):
Frequency: every 4 weeks

Dose: RPh will round up to the nearest combination of vial size (80mg, 200mg, 400mg) or ❑ Give exact dose (do NOT round)
❑ 4mg/kg IV over at least 1 hour ❑ 8mg/kg IV over at least 1 hour
❑ Other_____IV over 1 hour
** maximum of 800 mg per dose**
• Dilute in 100ml 0.9% Sodium Chloride for childern >30 kg and adults

Duration:❑ Refills x 1 year OR ❑ _____ infusions

LABS: every_____ (frequency)
❑ CBC with Diff ❑ AST/ALT ❑ Other:_____
NOTE:
• Orders are initated 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.