

### PATIENT INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_

### REFERRAL STATUS

New Referral       Dose or Frequency Change       Order Renewal

Is this the first dose?  Yes  No, date of last infusion: \_\_\_\_\_ Line type:  PIV  PICC  Port  Other

### DIAGNOSIS AND ICD-10 CODE

<input type="checkbox"/> Rheumatoid Arthritis	ICD-10 Code: _____
<input type="checkbox"/> Systemic Juvenile Idiopathic Arthritis (SJIA)	ICD-10 Code: _____
<input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis (PJIA)	ICD-10 Code: _____
<input type="checkbox"/> Other: _____	ICD-10 Code: _____

### REQUIRED DOCUMENTATION

<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> H&P and Clinical/Progress notes supporting primary diagnosis
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> TB Test Results	

List Tried & Failed Therapies, including duration of treatment:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

### MEDICATION ORDERS

<input type="checkbox"/> Actrema 4mg/kg IV over 60 minutes every 4 weeks	<input type="checkbox"/> Actemra 162mg SubQ every week
<input type="checkbox"/> Actemra 8mg/kg IV over 60 minutes every 4 weeks	<input type="checkbox"/> Actemra 162mg SubQ every 2 weeks
Note that doses >800mg for rheumatoid arthritis are not recommended.	<input type="checkbox"/> Actemra 162mg SubQ every ____ weeks
** Dose may be rounded to nearest vial size within +/-10%. TO PROHIBIT dose rounding check here <input type="checkbox"/>	

Refills:  X 6 months     X 1 Year     Other: \_\_\_\_\_

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

RN to flush and lock VAD/CVAD per company protocol

Other: \_\_\_\_\_

### PREMEDICATION ORDERS

<input type="checkbox"/> Acetaminophen 650mg PO prior to infusion	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Diphenhydramine 25mg PO prior to infusion	<input type="checkbox"/> Other: _____

### EMERGENCY MEDICATIONS

Administer the following medications as needed for infusion-related reactions per company protocol:

**Adults (weight >40kg):**

Diphenhydramine 25mg-50mg PO  
 Diphenhydramine 25mg-50mg slow IV push over 2-5 mins  
 Acetaminophen 325mg-650mg PO  
 Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated  
 Epinephrine 0.3mg IM/SQ, may repeat x1  
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive  
 Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

**Pediatrics (weight <40kg): (may adjust with weight changes)**

Diphenhydramine 25mg PO  
 Diphenhydramine 25mg slow IV push over 2-5 mins  
 Acetaminophen 325mg PO  
 Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated  
 Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1  
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

### PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_ NPI Number: \_\_\_\_\_  
 Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
 Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_