



Please fax completed form, insurance card, and clinical documentation to:  
**FAX: 843-793-6181**

**ACTEMRA ORDER**

New Start  Maintenance: Last Dose Given \_\_\_\_\_

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Allergies: _____		
Height: _____ Weight: _____		

**Indication:**

MO5. \_\_ Rheumatoid Arthritis  
 MO6. \_\_ Rheumatoid Arthritis w/o rheumatoid factor  
 M31.6 \_\_ Giant Cell Arteritis  
 Other \_\_\_\_\_

**DRUG:**

4mg/kg IV every 4 weeks  
 4mg/kg IV X 1 infusion then increase to 8mg/kg every 4 weeks  
 6mg/kg IV every 4 weeks- GCA  
 8mg/kg IV every 4 weeks  
 Other \_\_\_\_\_

**PREMEDICATION ORDERS:**

Acetaminophen:  1000mg PO  500mg PO 30 min prior to infusion.  
 Diphenhydramine:  25mg PO  50mg PO  25mg IVP 30 min prior to infusion.  
 Methylprednisolone:  62.5mg IVP  125mg IVP  Other \_\_\_\_\_ 30 min prior to infusion.  
 Other \_\_\_\_\_

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

**Referrals will not be processed until we receive ALL the following:**

- Face Sheet / Patient Demographics
  - Insurance card(s) – copy of front & back
  - Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
- Most Recent Labs (within last 4-8 weeks) – Required:
- CBC  CMP  Lipids  TB  Hep B Other: \_\_\_\_\_