



MOUNTAIN GRACE
HOME INFUSION

+1 833-360-1212 info@mginfusion.com

+1 (760) 400-6905

ACTEMRA

Date of order: _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Update Order ☐ Order Renewal

Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): ☐ M05 _____ ☐ M05 _____ ☐ M31.5 ☐ M31.6 ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: info@managecaresolutions.com

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- ☒ Deliver patient care in accordance with Mountain Grace Home Infusion clinical procedures and the medication's prescribing information (PI), including management of hypersensitivity reactions
- ☒ TB Status & Date (list results & attach clinicals): _____
- ☒ Recent CBC & CMP Labs (attach clinicals)

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ Other _____ ☐ every _____
- ☐ Please check this box if you DO NOT authorize Mountain Grace Home Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

- ☒ Tocilizumab Intravenous Infusion
- Dose:** ☐ 4mg /kg ☐ 6mg /kg ☐ 8mg /kg
- ☐ 10 mg /kg ☐ 12 mg /kg
- Doses exceeding 600mg per infusion are not recommended in GCA patients.
- Doses exceeding 800mg per infusion are not recommended in RA patients.
- ☐ Round up to nearest whole vial ☐ Give exact dose
- Frequency:** Every ☐ 2 weeks ☐ 4 weeks
- ☒ Refills: ☐ Zero/ ☐ for 12 months/ ☐ _____
- (if not indicated order will expire one year from date signed)
- To receive the brand-name medication, the prescribing provider must clearly write "Brand Medically Necessary" on the prescription. If this notation is absent, I4H may dispense an FDA-approved generic equivalent or biosimilar, when available.

PRE- MEDICATION ORDERS

Pre-meds not usually indicated

- ☐ Diphenhydramine ☐ 25mg / ☐ 50 mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 500mg / ☐ 650 mg ☐ PO
- ☐ Other: _____
- Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

Provider Name (Print) :

Provider Signature :

Date :

Please send it to this email: info@mginfusion.com