BluHaven HEALTH

Actemra Referral Form

Fax: (984) 370-2352
Phone: (984) 370-2350
Email: connect@bluhaven.com

Patient Information

Name: _____ DOB: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Weight: _____ ☐ lbs ☐ kgs

Allergies: ☐ NKDA ☐ _____

Required Documentation Insurance Card | History & Physical | Patient Demographics | Medication List | Baseline LFTs and Lipid Panel

TB Test Date: _____ Results: _____

Absolute Neutrophil Count Date: _____ Results: _____

Platelet Count Date: _____ Results: _____

Primary Diagnosis

☐ M31.6 Other giant cell arteritis
☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M06.00 Rheumatoid arthritis without rheumatoid factor, unspecified site
☐ Other: _____

Order Information

Lab Orders (Include frequency)

Please list any labs to be drawn by the infusion clinic: _____

☐ Absolute Neutrophil Count at month 2 and every 3 months thereafter
☐ Platelet Count at month 2 and every 3 months thereafter
☐ LFTs Count at month 2 and every 3 months thereafter

Pre-Medications

☑ Per infusion clinic protocol: No recommended standard pre-meds for Tocilizumab
☐ Provider Prescribed: _____

Primary Medication Order

**Actemra or biosimilar (Tyenne, Tofidence) may be used according to payor guidelines*

**To prohibit auto-substitution, please indicate specific brand required* _____

☐ Tocilizumab 4mg/kg (_____mg) IV every 4 weeks
☐ Tocilizumab 6mg/kg (_____mg) IV every 4 weeks
☐ Tocilizumab 8mg/kg (_____mg) IV every 4 weeks
☐ Other: _____

First Dose: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted: _____

Line Use/Care Orders

☑ Start PIV/ACCESS CVC
☑ Flush device per BluHaven Health's protocol (see BluHaven.com for policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box.

Adverse Reaction & Anaphylaxis Orders

☑ Administer acute infusion reaction and anaphylaxis medications per BluHaven Healths' protocol (see BluHaven.com for policy)
☐ Other: Please fax other reaction orders if checking this box.

Provider Information

Name: _____ Office Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

Provider Signature *Date*