ACTEMRA (TOCILIZUMAB) Referral Order Form

FAX (877) 637-6691

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☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)*

Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

ACTEMRA MEDICATION ORDERS

Patient Weight: ____ kg Dosing: ☐ mg/kg _____IV every weeks

Refills: _____

☐ SQ 162mg every week
☐ SQ 162mg every 2 weeks

INDICATION/DIAGNOSIS

☐ Rheumatoid Arthritis
☐ Polyarticular juvenile idiopathic arthritis
☐ Systemic juvenile idiopathic arthritis
☐ Other *(please specify in notes)*

***ICD-10 required**

NOTES (ADDITIONAL INFO)

_____
Referring Physician's Signature

_____
Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ HepB Surf Ag (w/in 12 months) ☐ HepB Core Ab (w/in 12 months) ☐ PPD Results (w/in 12 months)

☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY