

## 1 PATIENT INFORMATION

Patient's name \_\_\_\_\_  
 Date of birth \_\_\_\_\_  Male  Female Last 4 digits of SSN \_\_\_\_\_  
 Street address \_\_\_\_\_ Apt # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Parent/guardian (if applicable) \_\_\_\_\_  
 Home phone \_\_\_\_\_ Work phone \_\_\_\_\_  
 Cell phone \_\_\_\_\_ Evening phone \_\_\_\_\_  
 E-mail address \_\_\_\_\_  
 Insurance company name \_\_\_\_\_  
 Insurance company phone \_\_\_\_\_  
 Insured's name \_\_\_\_\_  
 Insured's employer \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_  
 Identification # \_\_\_\_\_ Policy/group # \_\_\_\_\_  
 Prescription card  Yes  No If yes, carrier \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Is patient eligible for Medicare?  Yes  No Please attach front and back copy of patient's insurance cards, if available.

## 2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date \_\_\_\_\_ Time \_\_\_\_\_  
 Prescriber's name and title \_\_\_\_\_  
 Office contact \_\_\_\_\_  
 Clinic/hospital affiliation \_\_\_\_\_  
 Street address \_\_\_\_\_ Suite # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 NPI # \_\_\_\_\_ License # \_\_\_\_\_  
 MD specialty \_\_\_\_\_

To reach your team, call toll-free 1 866 489-1899.  
 Please fax completed form to the RA team at 1 866 489-1901.

## 3 CLINICAL INFORMATION

Please complete for specific patient diagnosis.

Primary ICD-9 code: \_\_\_\_\_  
 Pertinent medical history and clinical course \_\_\_\_\_  
 Rationale for therapy: ICD-9 codes  
 714. Rheumatoid arthritis  555. Crohn's disease  722. Ankylosing spondylitis  
 696.0 Psoriatic with arthropathy  696.1 Psoriasis and similar disorders  556. Ulcerative colitis  
 714.3 Juvenile polyarticular rheumatoid arthritis  Other \_\_\_\_\_  
 Has the patient been treated previously for this condition?  Yes  No  
 Is patient currently on therapy?  Yes  No  
 Please list all therapies tried/failed: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## 4 PRESCRIBING INFORMATION

**Actemra®** (tocilizumab)  
 Dilute desired dose with normal saline to a total volume of 100 mL to be infused over 1 hour.  
 Patient weight (kg): \_\_\_\_\_  
 Dose:  4 mg/kg intravenous infusion every 4 weeks. Maximum dose of 800 mg/infusion.  
 8 mg/kg intravenous infusion every 4 weeks. Maximum dose of 800 mg/infusion. Qty: QS  
 **Orencia®** (abatacept)  
 Reconstitute each vial of *Orencia* with 10 mL of sterile water. Dilute desired dose to total of 100 mL in normal saline to be infused over 30 minutes. Patient weight (kg): \_\_\_\_\_  
 Dose:  500 mg (less than 60 kg)  750 mg (60-100 kg)  1000 mg (over 100 kg)  
 Juvenile arthritis 10 mg/kg if less than 75 kg Qty: QS  
 **Remicade®** (infliximab) 100 mg vial Qty: QS  
 Reconstitute each vial of *Remicade* with 10 mL of sterile water. Dilute desired dose to total of 250 mL in normal saline to be infused over a period NOT less than 2 hours. Patient weight (kg): \_\_\_\_\_  
**Starting dose:** \_\_\_\_\_ **Maintenance dose:** \_\_\_\_\_  
 5 mg/kg \_\_\_\_\_ mg IV at week: 0, 2, 6 ( \_\_\_\_\_ mg/kg) \_\_\_\_\_ mg IV every \_\_\_\_\_ weeks  
 3 mg/kg \_\_\_\_\_ mg IV at week: 0, 2, 6  
 Other \_\_\_\_\_ Qty: QS

**Prescription to include all necessary ancillary supplies (needles, syringes, etc.) to establish IV access and administer medication.**  
 Dispense:  1-month supply  3-month supply  Other \_\_\_\_\_ -month supply  
 Refill \_\_\_\_\_ times  
By signing below, I certify that the above therapy is medically necessary.  
 Prescriber's printed name \_\_\_\_\_  
 Prescriber's signature (sign below) \_\_\_\_\_

Dispense as written \_\_\_\_\_ Substitution allowed \_\_\_\_\_  
 Date \_\_\_\_\_

(Physician attests this is his/her legal signature. NO STAMPS)

## 4 PRESCRIBING INFORMATION

Patient name \_\_\_\_\_

Date of birth \_\_\_\_\_

Complete the following section if assistance from Accredo is requested in the coordination of your patient's infusion therapy.

*Actemra*® (tocilizumab) ( \_\_\_\_\_ mg/kg) \_\_\_\_\_ mg IV every \_\_\_\_\_ weeks

*Orencia*® (abatacept) \_\_\_\_\_ mg IV every \_\_\_\_\_ weeks

*Remicade*® (infliximab) ( \_\_\_\_\_ mg/kg) \_\_\_\_\_ mg IV every \_\_\_\_\_ weeks

Signature: \_\_\_\_\_

Preferred infusion setting:  Home  Infusion clinic

### Premedication orders

Acetaminophen 650 mg PO 30 min prior to infusion

Diphenhydramine 50 mg PO 30 min prior to infusion

Hydrocortisone 100 mg IV PO 30 min prior to infusion

Other \_\_\_\_\_

### Hypersensitivity/anaphylaxis orders

Stop infusion  Start normal saline at TKO

### Medicate with:

Epinephrine/*EpiPen*® 0.3 mg IM as needed for anaphylaxis.

Diphenhydramine 50 mg slow IVP PRN for urticaria, pruritis, SOB. Administer IM if there is no IV access.

Hydrocortisone 100 mg slow IVP PRN for urticaria, pruritis, SOB. Administer IM if there is no IV access.

Solumedrol 125 mg slow IVP PRN for urticaria, pruritis, SOB. Administer IM if there is no IV access.

### For anaphylactic reaction, activate 911.

Notify physician of type reaction and action taken. Verbal report and transfer care to EMS, if applicable.

### Flushing orders

Peripheral access

Central venous access

0.9% sodium chloride flush with \_\_\_\_\_ mL IV before and after medication and IVP for maintenance.

Heparin \_\_\_\_\_ units per mL. Flush with \_\_\_\_\_ units as final flush and as directed.

Labwork: \_\_\_\_\_

**Nursing:** Skilled nursing visit to establish venous access, administer medication, and assess general status and response to therapy.

Additional orders: \_\_\_\_\_

Prescriber's signature (sign below) \_\_\_\_\_

Date \_\_\_\_\_

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