CoxHealth at Home

ACTEMRA[®]

CoxHealth (to	ocilizumab)	Fax: 1-417-269-0692
Patient Information	Prescriber	
Name:DOB:	Prescriber name:	
Height: 🗅 in 🗅 cm Weight 🗅 kg 🖵 lk	bs NPI:	
Address:		
City: State: Zip:	City:	State: Zip:
Phone:Alternate:	Contact:	
SSN:	Phone:	Fax:
PLEASE INCLUDE ON FAX A COPY OF FRON AND BACK OF INSURANCE CARD(S) Clinical Information (Please fax all pertinent		information)
Diagnosis: M06.9 (Rheumatoid arthritis)		
Other:		
Allergies:		
Intravenous ACTEMRA [®]		
Flushing/Premedication Orders:		
 ✓ Flushing per CoxHealth at Home protocol 		
 ✓ PIV: 0.9% sodium chloride 3-20mL before and aft 	fter infusion as needed	
✓ Port: 0.9% sodium chloride 3-20mL into port at the fore and after infusion as needed, Heparin 100 under the solution of	time of access or at leas	-
\checkmark No routine premedication necessary. If desired, please wr	rite here:	
ACTEMRA [®] (tocilizumab) IV over at least 1 hour		
Frequency:		
✓ Every 4 weeks		
Dose: Rph will round up to the nearest combination of vial size	ize (80mg, 200mg, 400	mg)
🗅 4mg/kg 🗅 6mg/kg 🗅 8mg/kg 🖵 Other (max	x 800mg per dose) Dilu	ite in 100mL 0.9% sodium chloride
Quantity to dispense: 1 dose with 12 refills or infu	usion(s)	
Labs: every (frequency) 🗖 CBC with diff 🗖 CMP 🗖 O	Other:	
Prescriber's Signature:		Date
I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance pric stand that I can revoke this designation at any time by providing written notice to CoxHealth at Home.	ior authorization process for this prescription	on and any future fills of the same prescription for the patient listed above. I under-

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