

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F
 Ht: _____ Wt: _____ lbs kg Primary Language: _____
 Allergies: _____ Patient Preferred Location: _____

Diagnosis

Primary ICD 10 Code (Required)

M08.2 Juvenile Rheumatoid Arthritis, w/Systemic Onset
 M08.3 Juvenile Rheumatoid Polyarthritis (Seronegative)

Other: _____
 Other ICD 10 Code: _____
 Description: _____

Patient Status

New to therapy
 Continuing therapy (date of last dose _____)

Medication Order

Pre-Medications

Tylenol 650 mg PO
 Diphenhydramine 25 mg PO
 Diphenhydramine 25 mg IV
 Cetirizine 10 mg PO
 Methylprednisolone _____ mg IV

ACTEMRA (tocilizumab)

Cytokine Release Syndrome

One (1) dose per year
 (wt < 30 kg): 12 mg/kg IV
 (wt ≥ 30 kg): 8 mg/kg IV

Polyarticular Juvenile Idiopathic Arthritis

Every 4 weeks (no < 28 days) for one year
 (wt < 30 kg): 10 mg/kg IV
 (wt ≥ 30 kg): 8 mg/kg IV

System Juvenile Idiopathic Arthritis

Every 2 weeks (no < 14 days) for one year
 (wt < 30 kg): 12 mg/kg IV
 (wt ≥ 30 kg): 8 mg/kg IV

Doses exceeding 800 mg are NOT recommended for cytokine release syndrome

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments: _____

Lab Orders (Required)

- Negative TB
- CBC w/diff, platelets, AST, and ALT at second infusion; then every 8 weeks for Polyarticular JA and every 4 weeks for Systemic JIA
- Lipid panel at second infusion, then every 6 months

Lab Orders

Requested Add'l Lab Orders:

Lab Frequency: _____ every _____ weeks

Required Clinical Documentation

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Is the patient on any other disease modifying therapy?

Yes No

If yes, please note therapy and last dose:

Medix Infusion will collect all necessary labs if not included in referral documents

LAB RESULTS: Negative TB test within 12 months of therapy initiation;
 CBC w/diff, Platelets, AST, ALT, and lipid panel within 60 days

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

Contact Name: _____ Phone: _____ Fax: _____ Email: _____