PURE
INFUSION SUITES

# INFUSION ORDERS ACTEMRA

**UTAH PROVIDERS Fax form to:**
1-801-991-6924

**ALL OTHER PROVIDERS Fax form to:**
1-801-931-2631

*you must enter a 1 before the fax number*

## Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis

Allergies

***Please fax most recent labs and TB results and date.**

*ICD 10 CODE

*** Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

## ACTEMRA DOSING

- [ ] Actemra 4mg/kg IV Q 4 weeks: Refills for 1 year
- [ ] Actemra 8mg/kg IV Q 4 weeks: Refills for 1 year
- [ ] Actemra different dosing than above:

Refills:

Prescribing Provider

Address

City | State | ZIP Code

Provider Signature

Date / Time

Provider Phone | Provider Fax