



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION	
Primary ICD-10 Code (Please Specify Diagnosis): _____	
Secondary ICD-10 Code (Please Specify Diagnosis): _____	
Date of negative TB test: _____ <input type="checkbox"/> TB test pending, will fax results.	Patient is HBV negative or has been treated: <input type="checkbox"/> Yes <input type="checkbox"/> No
History of kidney disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, SCr: _____ GFR/CrCl: _____</i>	History of heart failure: <input type="checkbox"/> Yes <input type="checkbox"/> No
Required Labs/Results: <input type="checkbox"/> ANC: _____ <input type="checkbox"/> Platelet: _____ <input type="checkbox"/> SCr: _____ <input type="checkbox"/> Lipids: _____	
<input type="checkbox"/> AST: _____ Upper limit of normal: _____	<input type="checkbox"/> ALT: _____ Upper limit of normal: _____

ACTEMRA® ORDERS			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____			
Medication	Strength	Dose/Frequency	Refills
<input type="checkbox"/> Actemra (Tocilizumab)	<input type="checkbox"/> 20mg/mL vial <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4mg/kg IV every 4 weeks with max dose of 800 mg for weight >100 kg <input type="checkbox"/> 6mg/kg IV every 4 weeks with max dose of 600 mg for weight >100kg <input type="checkbox"/> 8 mg/kg IV every 4 weeks with max dose of 800 mg for weight >100kg <input type="checkbox"/> Other: _____	_____

INFUSION REACTION ORDERS
<p><b>Mild reaction protocol:</b></p> <p><input checked="" type="checkbox"/> Diphenhydramine 25mg IV, one time, for pruritus. <i>If symptoms worsen, see orders for moderate to severe reactions.</i></p> <p><b>Moderate reaction protocol:</b></p> <p><input checked="" type="checkbox"/> Acetaminophen 650mg PO, one time, for pyrexia or rigors <input checked="" type="checkbox"/> Diphenhydramine 50mg IV, one time, for pruritus or urticaria <input checked="" type="checkbox"/> Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms <i>If symptoms worsen, see interventions for severe reactions</i></p> <p><b>Severe reaction protocol: (Call 911 if initiated):</b></p> <p><input checked="" type="checkbox"/> Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (&gt;95%) <input checked="" type="checkbox"/> Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis</p>

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- Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
- Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms
- Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

**FLUSHING & LOCKING ORDERS**

**Flushing Protocol (>66lbs/33kg)**

**PIV and Midline:**

- 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion

**Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:**

- 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

**Locking Protocol (>66lbs/33kg)**

**PIV and Midline:**

- Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush

**PICC:**

- Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush

**Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:**

- Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**SIGNATURE**

We hereby authorize Infuse IQ LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X \_\_\_\_\_

Date: \_\_\_\_\_

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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