LivWell INFUSIONS

Actemra and Biosimilars

Fax 888 511-7654 *Phone 888 864-7341*

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

◯ M06.9 Rheumatoid Arthritis

◯ M31.6 Giant Cell Arteritis

◯ M08.09 unspecified juvenile rheumatoid arthritis

◯ Other: _____

ICD-10 _____

ALSO INCLUDE...

- Clinical/ Progress Notes
- Insurance Cards
- Demographics Sheet
- Current Medications
- Labs

ACTEMRA & BIOSIMILARS ORDER

Choose a medication: ◯ Actemra ◯ Tofidence ◯ Tyenna

IV Dosage & Frequency: _____ mg/kg IV every _____ weeks

SubCut Dosage and Frequency: ◯ SQ 162mg every week ◯ SQ 162mg every 2 weeks

Option available for Actemra and Tyenna Only

Patients weight (kg): _____

Date of last Infusion/Injection: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____