



Actemera Order Form

Select patient referral location: Anchorage Palmer Fairbanks

Please fax or securely email to 1-907-921-7669 or RX@luxinfusion.com.
For new referrals, please **include recent labs and last two office visit notes.**
Clinic Phone Number: 1-907-744-1944 · luxinfusion.com

1. PATIENT INFORMATION	
Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight:
Patient Status: New to therapy Continuing therapy	Next due date (if applicable):

2. PHYSICIAN INFORMATION	
Physician's Name:	NPI#:
License #: TIN#:	DEA#:
Address:	
City:	State: Zip:
Office contact:	Email:
Office phone:	Office fax:

3. DIAGNOSIS INFORMATION (and year of diagnosis)	
Rheumatoid Arthritis (_____) Polyarticular Juvenile Idiopathic Arthritis (_____) Other (specify): _____	
Systemic Juvenile Idiopathic Arthritis (_____) ICD 10 (_____)	

4. INSURANCE INFORMATION	
Please submit copies of the front and back or primary and secondary insurance cards with this referral.	

5. PRESCRIPTION INFORMATION (requires new order every 12 months)	
ACTEMRA	PRE-MEDICATIONS N/A
Administer _____ mg/kg IV every _____ weeks	Acetaminophen 500mg 650mg 1000mg PO
	Cetirizine (Zyrtec) 10mg PO (or other non-sedating anti-histamine)
	Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)
Vital signs per LUX Protocol	Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
Anaphylaxis & Hydration Management per LUX Protocol	Prednisone _____ mg PO
	Other: _____
	POST-MEDICATIONS N/A
	Acetaminophen 500mg 650mg 1000mg PO
	Prednisone _____ mg PO
	Other: _____

6. SIGNATURE (required)	
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PHYSICIAN'S SIGNATURE DATE