Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

TOCILIZUMAB

Infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:	
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Practice Address:	City: State:	Zip Code:

TOCILIZUMAB IV BRANDS:

☐**Actemra** ☐**Tyenne** ☐**Tofidence**

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Rheumatoid Arthritis (RA)
- ☐ _____ Giant Cell Arthritis (GCA)
- ☐ _____ Polyarticular Idiopathic Arthritis in > 2yro (PJIA)
- ☐ _____ Systemic Juvenile Idiopathic Arthritis (SJIA)

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

SPECIAL INSTRUCTIONS

TOCILIZUMAB ORDERS

DOSE:

- ☐ Initial dose of 4mg/kg every 4 weeks, then 8mg/kg every 4 weeks
- ☐ 4mg/kg every 4 weeks
- ☐ 8mg/kg evry 4 weeks
- ☐ Other_____

PATIENT WEIGHT

_____ lbs.

_____ kg

TOTAL DOSES:

☐ 1 yr _____ ☐ Other_____ ☐ Refill_____

Route: ☐ SQ ☐ IV

NOTES/ADDITIONAL COMMENTS:

If the medication selected above is not covered or is non-preferred by the patient's insurance, the prescribing provider authorizes consideration of the clinically appropriate alternatives listed below. Final medication selection will be based on provider clinical judgment and/or payer requirements. Provider signature below confirms authorization for the above substitution(s), if applicable.

TOCILIZUMAB IV BRANDS: ☐**Actemra** ☐**Tyenne** ☐**Tofidence**

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____