

Lexington
1792 Alysheba Way
Suite 205
Lexington, KY 40509

Bowling Green
727 U.S. 31 W Bypass
Suite 102
Bowling Green, KY 42101



TOCILIZUMAB

Infusion orders

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal
<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> Benefits Verification Only
<input type="checkbox"/> 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:	
<input type="checkbox"/> Actemra	<input type="checkbox"/> Tyenne
<input type="checkbox"/> Tofidence	

<p>DIAGNOSIS <i>Please provide ICD-10 code</i></p> <p><input type="checkbox"/> _____ Rheumatoid Arthritis (RA)</p> <p><input type="checkbox"/> _____ Giant Cell Arthritis (GCA)</p> <p><input type="checkbox"/> _____ Polyarticular Idiopathic Arthritis in > 2yro (PJIA)</p> <p><input type="checkbox"/> _____ Systemic Juvenile Idiopathic Arthritis (SJIA)</p>
<p>PRE-MEDICATION</p> <p><input type="checkbox"/> Tylenol 1000mg PO <input type="checkbox"/> Solu-Medrol 125mg IVP</p> <p><input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Solu-Cortef 100mg IVP</p> <p><input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Diphenhydramine 25mg IVP</p> <p><input type="checkbox"/> _____ (other) <input type="checkbox"/> _____ (other)</p>
<p>SPECIAL INSTRUCTIONS</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>

<p>TOCILIZUMAB ORDERS</p> <p>DOSE:</p> <p><input type="checkbox"/> Initial dose of 4mg/kg every 4 weeks, then 8mg/kg every 4 weeks</p> <p><input type="checkbox"/> 4mg/kg every 4 weeks</p> <p><input type="checkbox"/> 8mg/kg every 4 weeks</p> <p><input type="checkbox"/> Other _____</p>
<p>PATIENT WEIGHT</p> <p>_____ lbs.</p> <p>_____ kg</p>
<p>TOTAL DOSES:</p> <p><input type="checkbox"/> 1 yr _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Refill _____</p> <p>Route: <input type="checkbox"/> SQ <input type="checkbox"/> IV</p>

<p>NOTES/ADDITIONAL COMMENTS:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>
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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 _____