

Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Forest Hills
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Sheepshead Bay
2546 East 17th Street
Fl. 1
Brooklyn, NY 11235

Bronx
226 West 238th Street
Bronx, NY 10463

E 56th & Park Midtown
120 East 56 Street
Suite 300
New York, NY 10022

FIDJ
30 Broad Street
Suite 401
New York, NY 10004

Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003



Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Port Jefferson
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Southampton
625 Hampton Road
Southampton, NY 11968

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Holbrook
233 Union Avenue
Suite 207
Holbrook, NY 11741

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

Woodbury
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

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

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 Solu-Medrol 125mg IVP

Diphenhydramine 25mg PO Solu-Cortef 100mg IVP

Cetirizine 10mg PO Diphenhydramine 25mg IVP

_____ (other) _____ (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 every 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 _____