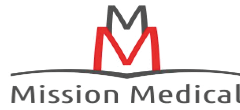
Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081

Office: 212-803-3339 Fax : 646-768-8600



Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

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 ________________