

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



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 _____