Local Infusion

MYLOCALINFUSION.COM

TOCILIZUMAB (AND BIOSIMILAR) ORDER FORM

❑ Tyenne (tocilizumab-aazg) ❑ Actemra (tocilizumab) ❑ Tofidence (tocilizumab-bavi)

❑ Dispense As Written (DAW) Will substitute for biosimilar or reference product based on insurance and availability

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments:_____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Rheumatoid Arthritis, ICD 10: M05._____ or M06._____

❑ Giant Cell Arteritis, ICD 10: M31._____

❑ Systemic Juvenile Idiopathic Arthritis (SJIA), ICD 10: M08.2_____

❑ Polyarticular Juvenile Idiopathic Arthritis (PJIA), ICD 10: M08._____

❑ Cytokine Release Syndrome (CRS), ICD 10: D89._____

❑ SSc-ILD, ICD 10: M34.81 (Actemra only)

❑ Other:_____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Tocilizumab	❑ 4 mg/kg ❑ 6 mg/kg ❑ 8 mg/kg ❑ 10 mg/kg ❑ 12 mg/kg	IV	❑ Every 2 weeks ❑ Every 4 weeks ❑ Other: _____

LABS / SPECIAL INSTRUCTIONS