

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX:  M  F HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_  LBS  KG

ALLERGIES: \_\_\_\_\_ PREFERRED CLINIC: \_\_\_\_\_

REFERRAL STATUS:  NEW REFERRAL  ORDER CHANGE  ORDER RENEWAL

**DIAGNOSIS & CLINICAL DOCUMENTATION**

**\*PLEASE COMPLETE ICD-10 FOR SPECIFIC DIAGNOSIS**

M05.\_\_\_\_ Rheumatoid arthritis, with Rheumatoid factor  M31.5 Giant cell arteritis w/ polymyalgia rheumatica

M06.\_\_\_\_ Rheumatoid arthritis, without Rheumatoid factor  M31.6 Other giant cell arteritis

ICD-10 CODE: \_\_\_\_\_ DESCRIPTION: \_\_\_\_\_

**REQUIRED DOCUMENTATION**

Insurance Information  List of Medications  Most recent History & Physical  Tried & Failed Therapies  Negative TB Screening  Negative Hep-B Screening

Liver Function Test results  Recent CBC w/ diff

**MEDICATION ORDER**

**\*Tocilizumab - Actemra or biosimilar (Tyenne) may be used according to payor guidelines**

To restrict substitution, indicate required brand here: \_\_\_\_\_

**For Rheumatoid Arthritis**

Tocilizumab 4 mg/kg IV in 100 ml NS over 60 minutes every 4 weeks (max dose 800 mg)

Tocilizumab 8 mg/kg IV in 100 ml NS over 60 minutes every 4 weeks (max dose 800 mg)

**For Giant Cell Arteritis**

Tocilizumab 6 mg/kg IV in 100 ml NS over 60 minutes every 4 weeks (max dose 600 mg)

OTHER: \_\_\_\_\_

**LAB ORDERS**

CBC w/ diff, Platelets, AST and ALT at 2nd infusion, then every 12 weeks

Lipid panel at 2nd infusion, then every six months

OTHER LAB: \_\_\_\_\_ FREQUENCY: \_\_\_\_\_

**PRE-MEDICATIONS**

**PO**

Acetaminophen: 650 mg

Cetirizine: 10 mg

Diphenhydramine: 25 mg

**IV**

Methylprednisolone: 125 mg

Diphenhydramine: 25 mg

OTHER: \_\_\_\_\_  PO  IV

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: \_\_\_\_\_

Patient to be observed for 30 minutes following the first infusion. Administer per protocol.  
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

**PRESCRIBER INFORMATION**

PROVIDER NAME: \_\_\_\_\_ NPI #: \_\_\_\_\_

EMAIL: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

ADDRESS (INCLUDE CITY, STATE, ZIP): \_\_\_\_\_

SUPERVISING PHYSICIAN: \_\_\_\_\_ CONTACT NAME: \_\_\_\_\_  
(IF APPLICABLE)

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN