

# 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  
  Famotidine 20 mg IV  
  Methylprednisolone (Solu-Medrol) 125 mg IVP  
 Benadryl 25mg PO  
  Cetirizine (Zyrtec) 10 mg PO  
 Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

## MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Tocilizumab	<input type="checkbox"/> 4 mg/kg <input type="checkbox"/> 6 mg/kg <input type="checkbox"/> 8 mg/kg <input type="checkbox"/> 10 mg/kg <input type="checkbox"/> 12 mg/kg	IV	<input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 4 weeks <input type="checkbox"/> Other: _____

## LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: \_\_\_\_\_

**FAX NUMBERS:**

- CT: 203.433.0621  
 FL: 904.877.9270

- MA: 413.296.8482  
 MD: 240.224.8607  
 ME: 207.407.7272

- NC: 919.984.8698  
 NH: 603.217.5371  
 NJ: 201.581.4521

- NY: 631.250.6020  
 OH: 937.871.4594  
 PA: 610.273.5998

- SC: 864.973.6279  
 VA: 703.202.0499