INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Tocilizumab *Actemra & biosimilars*

☐ Tyenne (tocilizumab-aazg) ☐ Actemra (tocilizumab) ☐ Tofidence (tocilizumab-bavi)
☐ Dispense as written (DAW) Will substitute for biosimilar or reference product based on insurance and availability unless DAW is checked.

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) _____ Provider NPI _____
Signature _____ Date _____
Contact name _____ Phone _____ Fax _____
Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB screen
☐ Demographics
☐ CBC with differential
☐ Labs and tests supporting diagnosis
☐ Liver function test
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Famotidine 20 mg IV
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

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

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