Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Tocilizumab Unspecified Plan of Treatment for Rheumatology

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies:	☐ See list ☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	M05.____ - Rheumatoid Arthritis with Rheumatoid factor	☐	M31.6 - Other Giant Cell Arteritis
☐	M06.____ - Rheumatoid Arthritis without Rheumatoid factor	☐	M31.5 - Giant cell Arthritis with Polymyalgia Rheumatica
☐	_____ - Other:		

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list / Tried and failed therapies
4	**REQUIRED:** TB screening for new start
5	HBV screening/labs as required by payor
6	Recent CBC with diff and LFTs

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:
LAST INFUSION DATE:
NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

NOTE: Patient may be ineligible to receive tocilizumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, new-onset abdominal symptoms, and/or surgery.

IV

Diphenhydramine	☐ 25mg	☐ 50mg		
Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:	
Famotidine	☐ 20mg	☐ 40 mg		
Other:	☐			

PO

Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg
Famotidine	☐ 20mg	☐ 40mg		
Diphenhydramine	☐ 25mg	☐ 50mg		
Fexofenadine	☐ 60mg	☐ 180mg		
Cetirizine	☐ 10mg			
Loratadine	☐ 10mg			
Other:	☐			

SPECIFIC MEDICATION:

☐ Actemra®
☐ Tyenne®

☐ **Any tocilizumab biosimilar may be used according to payer guidelines**

LAB ORDERS:

CBC with diff, platelets, ALT and AST prior to first dose, at 2nd infusion, and then every 12 weeks.

DOSE: Rheumatoid Arthritis

☐ 4mg/kg in 100mL NS every 4 weeks - IV over 1 hour
☐ 8mg/kg in 100mL NS every 4 weeks - IV over 1 hour

DOSE: Giant Cell Arteritis

☐ 6mg/kg in 100mL NS every 4 weeks - IV over 1 hour

SPECIAL/LAB ORDERS:

☐ _____
_____

LAB PARAMETERS: (Pharmacist to perform clinical lab monitoring)

On Initiation: ANC > 2000mm3; AST/ALT < 1.5 x ULN

Maintenance: **If ANC** is 500 to 1000 cells/mm^3, hold dose and notify referring MD. When ANC >1000 cells/mm^3 therapy may be resumed. If ANC < 500 cells/mm^3, then discontinue and notify referring MD. **If Platelet count** 50,000 to 100,000 cells/mm^3, hold dose. When platelet count is > 100,000 cells/mm^3, therapy may be resumed. If Platelet count is <50,000 cells/mm^3, then discontinue and notify referring MD. **If AST/ALT** are > 3-5 x upper limit normal HOLD dose and notify referring MD

Tocilizumab doses exceeding 800mg are not recommended.

Prescriber confirms that the patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment. Prescriber to monitor patient for symptoms of HBV and TB infection and reactivation as clinically appropriate.

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC
☑ Flush device per facility standard flushing procedure
☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- [ ] **Patient demographics - address, phone number, SS#, etc.**
- [ ] **Insurance information - copy of the card(s) if possible**
- [ ] **Plan of Treatment/Orders**
- [ ] **Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- [ ] **Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com