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

Tocilizumab Unspecified Pediatric – (over 2 years of age) Plan of Treatment

Rev 3.5.25

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)

- ☐ M08.2 - Juvenile Rheumatoid Arthritis with Systemic Onset
- ☐ M08.3 - Juvenile Rheumatoid Polyarthritis (seronegative)
- ☐ _____- Other: _____

REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list / Tried and failed therapies		NEXT INFUSION DATE:
4	**REQUIRED:** TB screening for new start patients		**IF ORDER CHANGE:**
5	HBV screening/labs as required by payor		☐ **Continue current order until insurance approved**
6	Recent CBC with diff and LFTs		

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		**PO**	Acetaminophen	☐ 325mg	☐ 500mg	☐ 160mg/5ml	mls
	Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:		Famotidine	☐ 20mg	☐ 40mg		
	Famotidine	☐ 20mg	☐ 40 mg			Diphenhydramine	☐ 25mg	☐ 50mg	☐ 12.5mg/5ml:	mls
	Other:	☐				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 4 weeks.

LAB PARAMETERS:

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

DOSE: for Polyarticular JIA every 4 weeks (No < 28 days)

- ☐ ☐ Less than 30 kg weight – 10mg/kg in 50ml NS - IV over 1 hour
- ☐ ☐ 30 kg or greater – 8mg/kg in 100ml NS - IV over 1 hour

DOSE: for Systemic JIA every 2 weeks (No < 14 days)

- ☐ ☐ Less than 30 kg weight – 12mg/kg in 50ml NS - IV over 1 hour
- ☐ ☐ 30 kg or above weight – 8mg/kg in 100ml NS - IV over 1 hour

SPECIAL ORDERS:

☐ ☐ _____

_____

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.

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 1.800.521.9640

- [ ] **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