Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

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:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
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	