

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

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

Rev. 4.29.25

PATIENT DEMOGRAPHICS:

Patient Name:	
Patient's Phone:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
<input type="checkbox"/> See list	<input type="checkbox"/> NKDA

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

<input type="checkbox"/> M08.2 - Juvenile Rheumatoid Arthritis with Systemic Onset
<input type="checkbox"/> M08.3 - Juvenile Rheumatoid Polyarthritis (seronegative)
<input type="checkbox"/> - 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	LAST INFUSION DATE:
3	Full medication list / Tried and failed therapies	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	REQUIRED: TB screening for new start patients	FROM PREVIOUS	IF ORDER CHANGE:
5	HBV screening/labs as required by payor	THERAPY:	
6	Recent CBC with diff and LFTs		
			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	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:

<input type="checkbox"/> Actemra®	<input type="checkbox"/> Any tocilizumab biosimilar may be used according to payer guidelines
<input type="checkbox"/> Tyenne®	

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 > 2000/mm³; AST/ALT < 1.5 x ULN
 Maintenance: If ANC is 500 to 1000 cells/mm³, hold dose and notify referring MD. When ANC > 1000 cells/mm³ therapy may be resumed. If ANC < 500 cells/mm³, then discontinue and notify referring MD. If Platelet count 50,000 to 100,000 cells/mm³, hold dose. When platelet count is > 100,000 cells/mm³, therapy may be resumed. If Platelet count is < 50,000 cells/mm³, 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)

<input type="checkbox"/> Less than 30 kg weight – 10mg/kg in 50ml NS - IV over 1 hour
<input type="checkbox"/> 30 kg or greater – 8mg/kg in 100ml NS - IV over 1 hour

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

<input type="checkbox"/> Less than 30 kg weight – 12mg/kg in 50ml NS - IV over 1 hour
<input type="checkbox"/> 30 kg or above weight – 8mg/kg in 100ml NS - IV over 1 hour

SPECIAL ORDERS:

<input type="checkbox"/>

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.

<input checked="" type="checkbox"/>	Refills x 12 months unless noted otherwise here:
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LINE USE/CARE ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure <input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.
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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



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