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 Plan of Treatment for Rheumatology

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:	☐ 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

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

SPECIAL/LAB 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	