Tocilizumab (Actemra, Tofidence, Tyenne)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• Recent CBC and LFTs • TB results: If TB results are positive, provide documentation of treatment or medical clearance, and a negative CXR

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ M31.6 Other giant cell arteritis ☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites ☐ M06.9 Rheumatoid arthritis, unspecified

☐ M06.00 Rheumatoid arthritis without rheumatoid factor, unspecified site ☐ M31.5 Systemic sclerosis-associated interstitial lung disease

☐ Rheumatoid arthritis: M05. M06. ☐ Giant cell arteritis: M31.

☐ Other:

PRIMARY MEDICATION ORDER

Tocilizumab (Actemra) or other tocilizumab product (as required by patient's health plan)

• Infuse intravenously over 60 minutes

• Flush with 0.9% sodium chloride at infusion completion

• Max dose should not exceed 800mg per infusion in RA patient patients and should not exceed 600mg per infusion in GCA patients

• Refill for 12 months unless otherwise noted: _____

DOSE	FREQUENCY
☐ 4 mg/kg	☐ Every 2 weeks
☐ 6 mg/kg	☐ Every 4 weeks
☐ 8 mg/kg	☐ Other: _____
☐ 10 mg/kg	
☐ 12 mg/kg	

SPECIAL INSTRUCTIONS

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

PRE-MEDICATION

Note: pre-meds not typically indicated for Tocilizumab

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ famotidine (Pepcid) 20 mg IV

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

☐ Other: _____

Dose: _____ Route: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

• It is recommended that tocilizumab not be initiated in patients with an absolute neutrophil count (ANC) below 2000 per mm3, platelet count below 100,000 per mm3, or who have ALT or AST above 1.5 times the upper limit of normal (ULN).

• Laboratory monitoring—recommended due to potential consequences of treatment-related changes in neutrophils, platelets, lipids, and liver function

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772

☐ Arbor Infusion Carmel (317) 981-1772