



RHEUMATOLOGY & INFUSION THERAPY CLINIC
Green Bay • Fox Valley • Marinette • Oshkosh
Phone: 920-430-8113 • Infusion Fax: 920-965-6389
osmsgb.com

Tocilizumab/Biosimilar (Any tocilizumab product as required by the patients' health plan*)

*Tocilizumab products include: Actemra, Tofidence, Avtozma, and Tyenne

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: ☐ Green Bay ☐ Neenah ☐ Marinette

PATIENT INFORMATION	
Date:	Patient Name: DOB:
☐ NKDA Allergies:	Weight (kg):
Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date:	Next Due Date:
PROVIDER INFORMATION	
Office Contact Name:	Office Email:
Prescribing Providers Name:	Provider NPI:
Office Address:	City: State: Zip:
Office Phone Number:	Office Fax Number:
DIAGNOSIS AND ICD 10 CODE	REQUIRED DOCUMENTATION
☐ Rheumatoid Arthritis ICD 10 Code: M06.9	☐ This signed order form by the provider
☐ Systemic Juvenile Idiopathic Arthritis (SJIA) ICD 10 Code: M08.09	☐ Patient demographics AND insurance information (copy of cards)
☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA) ICD 10 Code: _____	☐ Clinical/Progress notes
☐ Other: _____ ICD 10 Code: _____	☐ Lab and Tests supporting primary diagnosis
	☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody
	☐ Hepatitis C Test Results
	☐ TB Test Results
List Tried & Failed Therapies, including duration of treatment: 1. 2. 3.	
PREMEDICATION ORDERS	
☐ No premeds	
☐ Acetaminophen (Tylenol) PO ☐ 500mg ☐ 1000mg	
☐ Diphenhydramine (Benadryl) PO / IV ☐ 25mg ☐ 50mg (if route is not circled PO will be administered)	
☐ Methylprednisolone (Solu-Medrol) IV ☐ 125mg ☐ 62.5mg	
☐ Fexofenadine (Allegra) PO ☐ 180mg	
MEDICATION ORDERS (order will expire in 1 year unless otherwise specified)	
☐ Provider will select product (chosen based on patient's insurance coverage and availability) Available in 400mg, 200mg, & 800mg vials. Doses will be rounded to the nearest whole vial.	
Rheumatoid Arthritis Dosing	☐ Tocilizumab 4mg/kg IV every 4 weeks ☐ Tocilizumab 8mg/kg IV every 4 weeks ☐ Tocilizumab _____mg IV every 4 weeks *Please note that doses >800mg for RA are not recommended.
SJIA Dosing	☐ Tocilizumab 12mg/kg IV every 4 weeks (for patients weighing <30kg) ☐ Tocilizumab 8mg/kg IV every 4 weeks (for patients weighing > 30kg)
PJIA Dosing	☐ Tocilizumab 10mg/kg IV every 4 weeks (for patients weighing <30kg) ☐ Tocilizumab 8mg/kg IC every 4 weeks (for patients weighing ≥ 30kg)
Refills:	☐ X6 months ☐ X1 year ☐ _____ doses
<i>*Please note: If an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion, or discontinuing the medication.</i>	
LAB ORDERS	
☐ CBC w/ diff ☐ CMP ☐ CRP ☐ ESR ☐ Vitamin D OH Total ☐ Hep B Surface Antigen ☐ Quantiferon TB Gold ☐ Other: ☐ w/ every infusion ☐ w/ every other infusion ☐ Other:	

Provider Name (Print)

Provider Signature:

Date:

Fax Referral to 920-965-6389

All information contained in this order form is strictly confidential and will become a part of the patient's medical record.