Tocilizumab (Actemra, Tyenne, Tofidence)

Provider Order Form rev. 08/14/2025

PATIENT INFORMATION

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

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Rheumatoid Arthritis: Giant Cell Arteritis:

Other: Description:

THERAPY ADMINISTRATION *(Select one)*

☐ Infuse tocilizumab (Actemra) OR tocilizumab biosimilar in 100ml of 0.9% NS over 60mins as required by patient's insurance.

☐ Administer this tocilizumab product: _____ in 100ml of 0.9% NS over 60mins

DOSING *(Choose one)*

☐ RA/CRS: 4mg/kg x (_____ kg) = _____ mg
(Max dose should not exceed 800mg per infusion)

☐ RA/CRS: 8mg/kg x (_____ kg)= _____ mg
(Max dose should not exceed 800mg per infusion)

☐ GCA: 6mg/kg (_____ kg)= _____ mg
(Max dose should not exceed 600mg per infusion)

☐ OTHER: _____
(Max dose should not exceed 800mg per infusion)

FREQUENCY *(Choose one)*

☐ Every 4 weeks

☐ Every _____ weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

☑ CBC w/diff, AST, ALT at Week 4, then every 3 months

☑ Lipid Panel at Week 4, then every 6 months

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Signs or symptoms of illness or active infection.
- Planned/recent surgical procedures or recent live vaccines.
- New abdominal pain, fatigue, anorexia, dark urine, jaundice or neurological changes.
- For therapy continuation, ANC at least 1000 mm^3
- For initial therapy, ANC at least 2000mm^3
- PLT at least to 100,000 mm^3
- AST or ALT no greater than 1.5 times normal level

☑ Measure and record weight at each appointment

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, biologic agents, steroids, and disease modifying agents

Required Labs: Negative Hepatitis B, Negative TB within 12 months, Rheumatoid factor, CRP, ESR, ANC, ALT, AST, Platelets

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.