Tyenne® (tocilizumab-aazg) Referral Form

Patient Preferred Clinic (select one): _____

VIVO infusion

PATIENT INFORMATION

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

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

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

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

☐ CBC ☐ At each dose ☐ Every _____
☐ CMP ☐ At each dose ☐ Every _____
☐ CRP ☐ At each dose ☐ Every _____
☐ OTHER

***Vivo Infusion will perform pregnancy screening prior to every infusion per Vivo policy*

PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500 mg ☐ 650 mg ☐ 1000 mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
Other: _____
Dose: _____ Route: _____

TYENNE THERAPY ADMINISTRATION

☐ 4mg/kg IV every 4 weeks with max dose of 800 mg for weight >200 kg

☐ 6mg/kg IV every 4 weeks with max dose of 600 mg for weight >100kg
GCA ONLY

☐ 8 mg/kg IV every 4 weeks with max dose of 800 mg for weight >100kg.

☐ PJIA Indication:
- ☐ Less than 30 kg: 10 mg/kg every 4 weeks
- ☐ Greater than or equal to 30 kg: 8 mg/kg every 4 weeks

☐ SJIA Indication:
- ☐ Less than 30 kg: 12 mg/kg every 2 weeks
- ☐ Greater than or equal to 30 kg: 8 mg/kg every 2 weeks

REQUIRED DOCUMENTATION

☐ **Patient Demographics**
☐ **Insurance card/Information**
☐ **Progress Notes supporting DX**
☐ **Medication List and H&P**
☐ **Hep B Surface Antigen** (within 36 months)
☐ **TB results** (within 6 months)
☐ **Comprehensive Metabolic Panel**
☐ **Complete Blood Count**

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) **Provider Signature** **Date**

Fax Numbers

☐ Colorado: 303-418-4679
☐ Connecticut: 203-724-4838
☐ Florida: 904-930-4211
☐ Massachusetts: 800-540-1852
☐ Nevada: 702-489-5744
☐ New Jersey: 609-955-3711
☐ New York: 800-540-1852
☐ Ohio: 216-400-0674
☐ Oklahoma: 918-770-4421
☐ Pennsylvania: 215-399-9244
☐ Texas: 469-340-0044
☐ Virginia: 804-500-5941