

# Tyenne® (tocilizumab-aazg) Referral Form



**Patient Preferred Clinic** (select one):

**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  
 6mg/kg IV every 4 weeks with max dose of 600 mg *\*GCA ONLY\**  
 8 mg/kg IV every 4 weeks with max dose of 800 mg

**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**

- |                                     |   |
|-------------------------------------|---|
| <b>Patient Demographics</b>         | <b>Hep B Surface Antigen</b> (within 36 months) |
| <b>Insurance card/Information</b>   | <b>TB results</b> (within 6 months)             |
| <b>Progress Notes supporting DX</b> | <b>Comprehensive Metabolic Panel</b>            |
| <b>Medication List and H&amp;P</b>  | <b>Complete Blood Count</b>                     |

\*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
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<b>Email Referrals To: referrals@vivoinfusion.com OR Fax Below</b>		<b>Have a Question? Call (720) 902-4111</b>	
Colorado: 303-418-4679	Michigan: 833-957-2188	New York: 800-540-1852	Texas: 469-340-0044
Connecticut: 203-724-4838	Minnesota: 763-290-0903	Ohio: 216-400-0674	Virginia: 804-500-5941
Florida: 904-930-4211	Nevada: 702-489-5744	Oklahoma: 918-770-4421	Wisconsin: 414-600-5383
Massachusetts: 800-540-1852	New Jersey: 800-540-1852	Pennsylvania: 215-399-9244	