

Tyenne® (tocilizumab-aazg) Referral Form



Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status:

New Referral

Updated Referral

Referral 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 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:
Physician Preferred Method of Contact:	Email:	Fax:	Phone:

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)	40 mg	125 mg	IV	
hydrocortisone (Solu-Cortef)	100 mg	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 <i>*GCA ONLY*</i>
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

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

*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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Email Referrals To: referrals@vivoinfusion.com OR Fax Below		Have a Question? Call (720) 902-4111	
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: 781-202-1629	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244	