Tocilizumab Referral Form

Preferred Clinic (select one):

PATIENT INFORMATION

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 Infusion 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:

STANDING ORDERS

☑ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

CBC w/ diff every ______________________

CMP every ______________________

CRP every ______________________

OTHER ____

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

PREMEDICATIONS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25mg 50mg PO IV

methylprednisolone (Solu-Medrol) 40mg 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: ____

Dose: _______________ Route: ____________________

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

TOCILIZUMAB ADMINISTRATION

Infuse tocilizumab product as required by patient's insurance

Only use ________________ (subject to prior authorization)

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

Patient Demographics

Insurance card/Information

Progress Notes supporting DX

Medication List and H&P

TB results (within 6 months)

Comprehensive Metabolic Panel

Complete Blood Count

Hep B results (within 36 months)

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

Email Referrals To: referrals@vivoinfusion.com OR Fax Below   **Have a Question? Call (720) 902-4111**

Colorado: 303-418-4679	Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Oklahoma: 918-770-4421	Virginia: 804-500-5941
Connecticut: 203-724-4838	Michigan: 833-957-2188	New York: 800-540-1852	Pennsylvania: 215-399-9244	Wisconsin: 414-600-5383
Florida: 904-930-4211	Minnesota: 763-290-0903	Ohio: 216-400-0674	Texas: 469-340-0044	

Order is valid for one year unless otherwise noted.