

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

TB results (within 6 months)

Insurance card/Information

Comprehensive Metabolic Panel

Progress Notes supporting DX

Complete Blood Count

Medication List and H&P

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.****

Revision Date 04/2026