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 (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

☑ **Clinic Specimen Collection Authorization: If required labs are not received prior to appointment, infusion clinic staff are authorized to draw required labs under the referring provider's NPI and route results back to the referring office.**

☐ 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: _____

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	

Referral is valid for one year unless otherwise noted.

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