Troy Infusion Center
600 W Main Street
Suite 120
Troy, OH 45373
Phone: 937-401-6620
Fax: 937-401-6629

Washington Township Infusion Center
1989 Miamisburg-Centerville Road
Suite 101
Dayton, OH, 45459
Phone: 937-401-6620
Fax: 937-401-6629

Tocilizumab Order Form

Epic Referral: REF115252

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____ **ICD-10 Diagnosis:** _____

Certain reference medications may be substituted with FDA approved biosimilars based upon insurance requirements and/or KHN formulary substitutions. Final product is determined by these two factors – insurance requirements and preferred product.

Rx:

Tocilizumab IV infusion in 100mL NS: □ 4 mg/kg □ 6 mg/kg □ 8 mg/kg □ _____mg

note: maximum recommended dose is 800 mg

Preferred product: **Actemra** **Tyenne** **Other biosimilar:** _____

Infused over 1 hour

Frequency: □ Every 4 weeks □ Other_____

Order good for: □ 6 months □ 1-year Other duration: _____

Last date and type of TB test: _____ (please fax copy of results with order)

□ Perform annual TSPOT test at Kettering Health Infusion Center

Patients should also have recent CBC w/diff and LFTs on file (please fax copy of results with order)

□ Draw CBC w/diff and hepatic function panel every 3 months at Kettering Health Infusion Center

Pre-meds: (given at each infusion)

□ Tylenol 650 mg po or □ Tylenol 1000 mg po

□ Benadryl _____ mg po or □ Benadryl _____ mg IV

□ Other: _____

Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathflo (2 mg) PRN for patients with a port

Prescriber Printed Name:_____

Prescriber Full Address: _____

Office Phone Number: _____ **Office Fax Number:** _____

Prescriber Signature: _____ **Date:** _____