

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com

**TOCILIZUMAB ORDER FORM**

Patient Name: _____	ICD-10 Code: _____	Therapy Status ☐ New Start ☐ Continuing Therapy: _____ Last Dose: _____
Date of Birth: _____	Allergies: _____	
Weight: _____ lbs OR _____ kg		

PROVIDER INFORMATION

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

MEDICATION ORDER

Tocilizuab Therapeutic interchange to insurance preferred biosimilar authorized unless otherwise specified below: ☐ Do not use biosimilar	☐ Tocilizuab _____ mg/kg IV every _____ weeks to be given over one hour per protocol. ☐ (<100kg) Tocilizuab 162mg SQ to be given weekly per protocol. ☐ (>100kg) Tocilizuab 162mg SQ to be given every other week. Max dose of 800mg (max dose of 600mg if indicated for Giant Cell Arteritis)	Refills for one year from date of signature unless indicated below. _____ Refills	<i>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</i> ✓ Negative TB result and date: _____, Hepatitis B Surface Antigen.
---	---	--	--

PRE-MEDICATIONS

<u>Oral</u> ☐ Acetaminophen: _____ 325mg _____ 500mg _____ 650mg ☐ Loratadine: 10mg ☐ Cetirizine: 10mg ☐ Diphenhydramine: _____ 25mg _____ 50mg ☐ Famotidine: _____ 20mg _____ 40mg ☐ Ibuprofen: _____ 200mg _____ 400mg _____ 600mg ☐ Ondansetron: _____ 4mg _____ 8mg ☐ Other: _____	<u>IV</u> ☐ Dexamethasone: _____ 4mg _____ 8mg ☐ Diphenhydramine: _____ 25mg _____ 50mg ☐ Famotidine: _____ 20mg _____ 40mg ☐ Methylprednisolone: 125mg ☐ Hydrocortisone: 100mg ☐ Ondansetron: _____ 4mg _____ 8mg ☐ Other: _____
---	--

LAB ORDERS (please indicate any labs to be drawn and frequency)**OTHER REQUIRED DOCUMENTATION**

Surveillance lab ordering and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 615-278-3355) • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
--	---

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)*By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.*

Prescriber Signature _____

Date _____