Tocilizumab Product Order Form

Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Demographics

Patient Name: _____ Ordering Provider: _____

DOB: _____ NPI: _____

Phone number: _____ Primary Care Provider: _____

Allergies: _____ Insurance Information: _____

Referral Status

☐ New Referral

☐ Dose or Frequency Change

☐ Order Renewal

Has the patient been treated for this condition previously?

☐ No ☐ Yes, medication(s): _____

_____

Diagnosis & Required Information

Diagnosis ICD10 Codes:

☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA)

☐ Rheumatoid Arthritis: M06.___ (enter remaining ICD-10 code)

☐ Juvenile Arthritis: M08. ____(enter remaining ICD-10 code)

☐ TB Test Results: Please send chest x- ray results if TB is indeterminant.

☐ Other:_____

Required Information:

☐ Patient Face Sheet

☐ Labs/Tests supporting diagnosis.

☐ Clinical/Progress Note

Medication Order

Pre-Medications: Per infusion

☐ Acetaminophen (Tylenol) tablet, oral,
- ☐ 650 mg
- ☐ Other: _____

☐ Famotidine IV,
- ☐ 40 mg

☐ Cetirizine (Zyrtec) tablet, oral
- ☐ 10 mg

☐ Methylprednisolone sodium succinate (Solu-Medrol) IV,
- ☐_____mg

Drug: ***Subject to prior authorization. OSG formulary products include: Tofidence, Tyenne***

☐ Tocilizumab or Biosimilar *(Oregon Specialty Infusion will determine product based upon patient's insurance & benefits investigation)*

— OR —

☐ Do not substitute: _____

Tocilizumab or biosimilar: Max Dose 800 mg

Initial Dose: Select one:

☐ IV 4 mg/ kg

☐ IV 8 mg/kg

☐ Other: _____

Maintenance Dose: Select one

☐ IV: Infuse 4mg/kg every 4 weeks for 1 year

☐ IV: Infuse 8mg/kg every 4 weeks for 1 year

☐ Other: _____

Patient Weight: _____lbs

Patient Height: _____in

Labs:

☐ Complete Metabolic Panel, routine, ONCE every _____ ☐ Days ☐ Weeks ☐ Months

☐ CBC with differential, Routine, ONCE every _____ ☐ Days ☐ Weeks ☐ Months

☐ Other: _____

☒**OSI Hypersensitivity protocol: Solumedrol, Benadryl, or Famotidine could be used in the event of a hypersensitivity reaction. Referring office will be notified if this occurs**

Physician's Signature: _____ Date: _____

Provider Name: _____ Office Phone: _____ Office Fax: _____

Fax completed form to (503) 540-3105

Questions? Call us at (503) 540-9999

Updated 5/2025