



PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
 Primary Language: _____ Allergies: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

- | | |
|--|--|
| <input type="checkbox"/> M05. _____ Rheumatoid Arthritis w/Rheumatoid Factor | <input type="checkbox"/> D89.83 Cytokine Release Syndrome |
| <input type="checkbox"/> M06. _____ Rheumatoid Arthritis w/o Rheumatoid Factor | <input type="checkbox"/> M08.3 Polyarticular Juvenile Idiopathic Arthritis |
| <input type="checkbox"/> M31.6 _____ Giant Cell Arteritis | <input type="checkbox"/> M08.2 Systemic Juvenile Idiopathic Arthritis |
| <input type="checkbox"/> Other: _____ | |

REQUIRED: Demographics & Most Recent: H&P, clinical notes, labs, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy

LAB RESULTS: Include negative TB and negative Hepatitis B (if positive, provide documented medical treatment or clearance) prior to initiating therapy

PRESCRIPTION

Pre-Medications

- | | |
|---|--|
| <input type="checkbox"/> Acetaminophen: 650 mg PO | <input type="checkbox"/> Acetaminophen: _____ mg PO |
| <input type="checkbox"/> Cetirizine 10 mg PO | <input type="checkbox"/> Famotidine: _____ mg IV |
| <input type="checkbox"/> Dexamethasone: _____ mg IV | <input type="checkbox"/> Loratadine 10 mg PO |
| <input type="checkbox"/> Diphenhydramine: 25 mg PO | <input type="checkbox"/> Methylprednisolone: _____ mg IV |
| <input type="checkbox"/> Diphenhydramine: 25 mg IV | <input type="checkbox"/> Ondansetron 4 mg IV |

Lab Orders

- CBC w/diff: every _____ weeks month
 CMP: every _____ weeks month
 Other: _____ weeks month

Drug

- Tocilizumab or Biosimilar as dictated by patient's insurance. *
***Oregon Specialty Infusion will determine appropriate product based upon benefit investigation**
OR
 Tocilizumab product _____ (DO NOT SUBSTITUTE)

Adverse Events: In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

Dose and Frequency

- IV:** infuse 4 mg/kg every 4 weeks for _____ doses followed by 8 mg/kg every 4 weeks x 1 year
 IV: infuse 4 mg/kg every 4 weeks x 1 year
 IV: infuse 6 mg/kg every 4 weeks x 1 year
 IV: infuse 8 mg/kg every 4 weeks x 1 year

**** Dose to not exceed 800 mg in RA/CRS diagnosis. Dose to not exceed 600 mg in GCA diagnosis. If calculated dosage exceeds the maximum recommended dose, Oregon Specialty Infusion will administer maximum recommended dose. ****

Is the patient on any other disease modifying therapy? Yes No
 If yes, please note therapy and last dose: _____

PRESCRIBING INFORMATION

Prescriber Name: _____ Signature: _____
 Date: _____ NPI # _____ Specialty: _____
 Office phone #: _____ Office Fax #: _____