

Loqtorzi (toripalimab-tpzi)

Provider Order Form rev. 1/12/2026



PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Full Name: _____ DOB: _____ Phone: _____ Gender: M F Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? Yes, (Send a copy) No (AIC will process)

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

C11.0 Malignant neoplasm of lateral wall of nasopharynx
 C11.1 Malignant neoplasm of superior wall of nasopharynx
 C11.2 Malignant neoplasm of posterior wall of nasopharynx
 C11.3 Malignant neoplasm of anterior wall of nasopharynx
 C11.8 Malignant neoplasm of overlapping sites of nasopharynx.
 C11.9 Malignant neoplasm of Waldeyer's ring

C14.0 Malignant neoplasm of nasopharynx, unspecified
 C14.2 Malignant neoplasm of pharynx, unspecified
 C30.0 Malignant neoplasm of nasal cavity
 D37.05 Neoplasm of uncertain behavior of pharynx
 Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

Acetaminophen (Tylenol) 500mg 650mg 1000mgPO
 Cetirizine (Zyrtec) 10mgPO
 Loratadine (Claritin) 10mgPO
 Diphenhydramine (Benadryl) 25mg 50mg PO IV
 Methylprednisolone (Solu-Medrol) 40mg 125mg IV
 Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Complete metabolic panel, liver enzymes, thyroid panel
 Other: _____

Loqtorzi (toripalimab-tpzi) (Select one):

250 mg intravenously every three weeks
 3 mg/kg intravenously every two weeks

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

Refills: zero 6 months 12 months _____ (*Prescription valid for one year, unless otherwise indicated*)

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print)

Provider Signature

Date