Tocilizumab
(Actemra, Tyenne, Tofidence)
Provider Order Form *rev. 1/12/2026*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

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)

☐ M31.6 Other giant cell arteritis
☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M06.00 Rheumatoid arthritis without rheumatoid factor, unspecified site
☐ 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: Baseline LFT, Lipid Panel, TB Test Result,
-Absolute Neutrophil Count at month 2 and every 3 months thereafter
-Platelet Count at month 2 and every 3 months thereafter
-LFTs Count at month 2 and every 3 months thereafter
List Any Labs to be drawn at the infusion clinic:
_____
Other Labs: _____

Tocilizumab (Select one):

☐ *Infuse tocilizumab product as required by patients insurances*
- ☐ 4 mg/kg IV every 4 weeks for _____ doses, followed by 8 mg/kg every 4 weeks for one year
- ☐ 4 mg/kg IV every 4 weeks for one year
- ☐ 8 mg/kg IV every 4 weeks for one year

-OR-

☐ ONLY USE ☐ Actemra ☐ Tyenne ☐ Tofidence *(subject to prior authorization)*

Tocilizumab (Actemra®) refill as directed x 1 year
- ☐ Infuse _____ mg/kg IV over 60 minutes every 4 weeks – max 800 mg.
- ☐ Inject 162 mg SubQ once ☐ every week or ☐ every other week.

Tocilizumab-aazg (Tyenne®) refill as directed x 1 year
- ☐ Infuse _____ mg/kg IV over 60 minutes every ☐ 2 or ☐ 4 weeks – max 800 mg.
- ☐ Inject 162 mg SubQ once ☐ every week or ☐ every other week.

Tocilizumab-bavi (Tofidence®) refill as directed x 1 year
- ☐ Infuse _____ mg/kg IV over 60 minutes every ☐ 2 or ☐ 4 weeks – max 800 mg.

☐ Other: _____

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*

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc)**: F: 469.305.2361 P: 972.865.4454**

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