Tocilizumab for Rheumatic Diseases

Referring Physician Orders Rev. 4/2026

Please fax completed referral form & all required documents to 770-618-9617

CPS INFUSION

PATIENT DEMOGRAPHICS

Insurance Information: Please attach copy of insurance card* front and back *(required)

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

DIAGNOSIS*

ICD-10 CODE *(required)* ***Please complete 2nd and 3rd digits to complete ICD-10 for billing***

☐ M05.____ Rheumatoid Arthritis with Rheumatoid factor

☐ M06.____ Rheumatoid Arthritis without Rheumatoid factor

☐ M31.6 Other Giant Cell Arteritis

☐ M31.5 - Giant Cell Arteritis with Polymyalgia Rheumatica

☐ Other: _____, ICD-10 _____

INFUSION ORDERS

MEDICATION

Tocilizumab and biosimilars

☐ Actemr® ☐ Tyenne® ☐ Tofidence®

DOSE

☐ _____mg (4mg/kg)

☐ _____mg (8mg/kg)

DIRECTIONS/DURATION

☐ Infuse IV over 1 hour every 4 weeks x 1 year

Is patient currently receiving therapy above from another facility? ☐ NO ☐ YES

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

PRE-MEDICATION ORDERS:

☐ No premeds ordered at this time ☐ Diphenhydramine 25mg PO ☐ Other: _____

☐ Acetaminophen 650mg PO ☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

TEST RESULTS *(required)*

- TB screening for Actemra, Cimzia, Cosentyx, infliximab biosimilars, Orencia, and Simponi Aria (submit results from within 12 months to start therapy and annually to continue therapy)
  - Annual TB screening to be done by: ☐ Infusion Center ☐ Referring Physician

Hepatitis B Screening for Cimzia, infliximab biosimilars, Orencia, Simponi Aria, tocilizimab biosimilars and Rituxan (submit results to start therapy)

DIAGNOSTIC TEST RESULTS (please attach copy for all items checked)

For SLE: ☐ Autoantibody test (ANA, anti-dsDNA)

PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

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