Infusion Site: ☐ OAOC Infusion Center ☐ Kirkland Specialty Infusions

Actemra ® | (Tocilizumab)

Please fax a copy of the following patient information:

☐ Demographics ☐ Insurance information ☐Current Lab Results ☐H&P ☐ Current Medication

Patient Information

Patient Name:_____ DOB:_____
Allergies:_____ Weight: _____ lbs/kg Height:_____
Diagnosis/ ICD-10:
☐ Rheumatoid arthritis, unspecified / M06.9
☐ Other giant cell arteritis / M31.6
☐ Systemic Sclerosis-Associated Interstitial Lung Disease / M34.81
☐ Polyarticular Juvenile Idiopathic Arthritis / M08.09
☐ Cytokine Release Syndrome (CRS) / D89.839
☐ Other (please specify) _____
Additional information:
_____

Provider Information

Printed Provider's Name:
_____
Phone: _____ Fax:_____
Office Address:
_____
Contact Person:_____

Medication Information

Dose:_____ Frequency and Duration: _____
Start Date of Infusion:_____ End Date of Infusion:_____
Other Orders or Special Instructions:
_____

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Fax : (425) 533-2540
Email: infusion@overlakearthritis.com

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