Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Rheumatoid Arthritis	ICD 10 Code: M06.9
☐ Systemic Juvenile Idiopathic Arthritis (SJIA)	ICD 10 Code: M08.09
☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA)	ICD 10 Code: _____
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider	☐ Clinical/Progress notes (must be within 1 year)
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
*Patient may be required to submit a pregnancy test prior to treatment	☐ TB Test Results (must be within 1 year)
	☐ Baseline Liver Function Test

List Tried & Failed Therapies, including duration of treatment:

1)

2)

3)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI: **Patient weight required for weight-based orders.

Rheumatoid Arthritis Dosing	☐ J3262 Actemra 4mg/kg IV every 4 weeks ☐ J3262 Actemra 8mg/kg IV every 4 weeks ☐ J3262 Actemra _____ mg IV every 4 weeks Please note that doses >800mg for RA are not recommended.
SJIA Dosing	☐ J3262 Actemra 12mg/kg IV every 4 weeks (for patients weighing <30kg) ☐ J3262 Actemra 8mg/kg IV every 4 weeks (for patients weighing ≥ 30kg)
PJIA Dosing	☐ J3262 Actemra 10mg/kg IV every 4 weeks (for patients weighing <30kg) ☐ J3262 Actemra 8mg/kg IV every 4 weeks (for patients weighing ≥ 30kg)

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Ph. 217-258-4150
Suite 204 Fax 217-348-2579
Mattoon, IL 61938

☐ EFFINGHAM
901 Medical Park Dr. Ph. 217-342-7500
Suite 201 Fax 217-342-7499
Effingham, IL 62401

INFUSION ORDERS - ACTEMRA (TOCILIZUMAB)

Clinics Scan to: Physician Orders