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

☐ Relapsing-Remitting Multiple Sclerosis	ICD 10 Code: G35
☐ Secondary Progressive Multiple Sclerosis	ICD 10 Code: G35
☐ Primary Progressive Multiple Sclerosis	ICD 10 Code: G35
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
☐ Other: _____	ICD 10 Code: _____

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

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ Tried and Failed therapies
  *Patient may be required to submit a pregnancy test prior to treatment
- ☐ Clinical/Progress notes (must be within 1 year)
- ☐ Labs and Tests supporting primary diagnosis
- ☐ Hepatitis B Test Results: HBsAg & HepB Core w/reflex IgG and IgM
- ☐ Anti-JCV antibodies test result

If MS, current MS treatment and end of current therapy date:

Is your patient currently enrolled in the TOUCH (FDA REMS) program? ☐ Yes ☐ No

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Dosing
- ☐ J2323 Tysabri 300mg IV every 4 Weeks
- ☐ J2323 Tysabri 300mg IV every _____ weeks

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

PREMEDICATIONS

- ☐ Acetaminophen 650mg PO
- ☐ Diphenhydramine 25mg IV Push or PO
- ☐ Methylprednisolone 100mg Slow IV Push
- ☐ Other: _____

ADDITIONAL ORDERS / INFORMATION

- ☐ Urine pregnancy test prior to first infusion

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. Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

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

INFUSION ORDERS - TYSABRI (NATALIZUMAB)

Clinics Scan to: Physician Orders