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

☐ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
☐ Rheumatoid Arthritis	ICD 10 Code: M06.9
☐ Ankylosing Spondylitis	ICD 10 Code: M45.9
☐ Psoriatic Arthritis	ICD 10 Code: L40.52
☐ Plaque Psoriasis	ICD 10 Code: L40.0
☐ 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
- ☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody

*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
- ☐ TB Test Results

List Tried & Failed Therapies, including duration of treatment:

1)

2)

MEDICATION ORDERS

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

Initial Dosing	☐ J1745 Remicade 5mg/kg IV at week 0, 2, 6 then every 8 weeks thereafter
Maintenance Dosing	☐ J1745 Remicade 5mg/kg IV every 8 weeks
Alternative Dosing	☐ J1745 Remicade _____ IV every _____ weeks

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

PREMEDICATIONS

- ☐ Acetaminophen 650mg PO
- ☐ Diphenhydramine 25mg IV Push or PO
- ☐ Methylprednisolone 40mg Slow IV Push
- ☐ Other: _____

Please note: if an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.

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.
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 - REMICADE (INFLIXIMAB)

Clinics Scan to: Physician Orders