

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

PATIENT INFORMATION			
Name:			DOB:
Allergies:		Date of Referral:	
REFERRAL STATUS			
<input type="checkbox"/> New Referral		<input type="checkbox"/> Dose or Frequency Change	<input type="checkbox"/> Order Renewal
INFUSION OFFICE PREFERENCES (Optional)			
Preferred Location* <input type="checkbox"/> Mattoon		<input type="checkbox"/> Effingham	
<small>*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.</small>			
Diagnosis and ICD 10 CODE			
<input type="checkbox"/> Rheumatoid Arthritis (RA)		ICD 10 Code: M05.9	
<input type="checkbox"/> Systemic Juvenile Idiopathic Arthritis (SJIA)		ICD 10 Code: M08.20	
<input type="checkbox"/> Other: _____		ICD 10 Code: _____	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)			
<input type="checkbox"/> This signed order form by the provider		<input type="checkbox"/> Clinical/Progress notes (must be within 1 year)	
<input type="checkbox"/> Patient demographics AND insurance information		<input type="checkbox"/> Labs and Tests supporting primary diagnosis	
<small>*Patient may be required to submit a pregnancy test prior to treatment</small>		<input type="checkbox"/> TB Test Results (must be within 1 year)	
List Tried & Failed Therapies, including duration of treatment:			
1)			
2)			
3)			
MEDICATION ORDERS			
<b>Dosing Wt for Calculations</b>		Ht:	Wt (in kg):
		BMI:	
<b>Dosing (RA and SJIA &gt;75kg)</b>		<input type="checkbox"/> J0129 Orencia 500mg (Weight <60kg) IV at week 0, 2, 4 then every 4 weeks	
		<input type="checkbox"/> J0129 Orencia 750mg (Weight 60-100kg) IV at week 0, 2, 4 then every 4 weeks	
		<input type="checkbox"/> J0129 Orencia 1000mg (Weight >100kg) IV at week 0, 2, 4 then every 4 weeks	
		<input type="checkbox"/> Maintenance: J0129 Orencia _____ mg IV every 4 weeks	
<b>SJIA Dosing (&lt;75kg)</b>		<input type="checkbox"/> J0129 Orencia 10mg/kg IV at week 0, 2, 4 then every 4 weeks (Max dose = 1000mg)	
		<input type="checkbox"/> Maintenance: J0129 Orencia 10mg/kg IV every 4 weeks (Max dose = 1000mg)	
<b>Duration</b>		<input type="checkbox"/> X 6 months	
		<input type="checkbox"/> X 1 year	
		<input type="checkbox"/> _____ 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