Sarah Bush Lincoln

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

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody
- ☐ Pregnancy Test (if applicable)
- ☐ Clinical/Progress notes
- ☐ Labs and Tests supporting primary diagnosis
- ☐ TB Test Results

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.

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

Refills: ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

PREMEDICATIONS

- ☐ Acetaminophen 650mg PO prior to Renflexis infusion
- ☐ Diphenhydramine 25mg PO prior to Renflexis infusion
- ☐ Methylprednisolone 40mg Slow IV Push PRN infusion reaction
- ☐ 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

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 - RENFLEXIS (INFLIXIMAB-abda)

Clinics Scan to: Physician Orders