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

☐ Rheumatoid Arthritis (RA)	ICD 10 Code: M05.9
☐ Systemic Juvenile Idiopathic Arthritis (SJIA)	ICD 10 Code: M08.20
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ TB Test Results	☐ Pregnancy Test (if applicable)

List Tried & Failed Therapies, including duration of treatment:

1)

2)

3)

MEDICATION ORDERS

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

Dosing (RA and SJIA >75kg) **J0129**	☐ Orencia 500mg (Weight <60kg) IV at week 0, 2, 4 then every 4 weeks ☐ Orencia 750mg (Weight 60-100kg) IV at week 0, 2, 4 then every 4 weeks ☐ Orencia 1000mg (Weight >100kg) IV at week 0, 2, 4 then every 4 weeks ☐ Maintenance: Orencia _____mg IV every 4 weeks
SJIA Dosing (<75kg)	☐ Orencia 10mg/kg IV at week 0, 2, 4 then every 4 weeks (Max dose = 1000mg) ☐ Maintence: Orencia 10mg/kg IV every 4 weeks (Max dose = 1000mg)

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

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 - ORENCIA (ABATACEPT)

Clinics Scan to: Physician Orders