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 Rheumatoid Arthritis (RA)	ICD 10 Code: M06.9
☐ Active Psoriatric Arthritis	ICD 10 Code: L40.52
☐ Active Ankylosing Spondylitis	ICD 10 Code: M45.9
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION

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

List Tried & Failed Therapies, including duration of treatment:

1)

2)

3)

MEDICATION ORDERS

**Patient weight required for weight-based orders.

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

Initial Dosing	☐ Simponi Aria 2mg/kg IV at week 0, 4 then every 8 weeks thereafter
Maintenance Dosing	☐ Simponi Aria 2mg/kg IV every 8 weeks ☐ Other: Simponi Aria _____ IV at every _____ weeks

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 - SIMPONI ARIA (GOLIMUMAB)

Clinics Scan to: Physician Orders