

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	
*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.			
Diagnosis and ICD 10 CODE			
<input type="checkbox"/> Rheumatoid Arthritis	ICD 10 Code: M06.9		
<input type="checkbox"/> Systemic Juvenile Idiopathic Arthritis (SJIA)	ICD 10 Code: M08.09		
<input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis (PJIA)	ICD 10 Code: _____		
<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	
*Patient may be required to submit a pregnancy test prior to treatment		<input type="checkbox"/> TB Test Results (must be within 1 year)	
<input type="checkbox"/> Baseline Liver Function Test			
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.
Rheumatoid Arthritis Dosing	<input type="checkbox"/> J3262 Actemra 4mg/kg IV every 4 weeks <input type="checkbox"/> J3262 Actemra 8mg/kg IV every 4 weeks <input type="checkbox"/> J3262 Actemra _____ mg IV every 4 weeks Please note that doses >800mg for RA are not recommended.		
SJIA Dosing	<input type="checkbox"/> J3262 Actemra 12mg/kg IV every 4 weeks (for patients weighing <30kg) <input type="checkbox"/> J3262 Actemra 8mg/kg IV every 4 weeks (for patients weighing ≥ 30kg)		
PJIA Dosing	<input type="checkbox"/> J3262 Actemra 10mg/kg IV every 4 weeks (for patients weighing <30kg) <input type="checkbox"/> J3262 Actemra 8mg/kg IV every 4 weeks (for patients weighing ≥ 30kg)		
Duration	<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: SBL Infusion Center
 Ph. 217-258-4150
 217-342-7500
 Fax Completed Form and all documentation to: Fax 217-342-7499