Sarah Bush Lincoln

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

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

Diagnosis	ICD 10 Code
☐ Ankylosing Spondylitis	ICD 10 Code: M45.9
☐ Non-radiographic Axial Spondyloarthritis	ICD 10 Code: M45.A0
☐ Psoriatic Arthritis	ICD 10 Code: L40.50
☐ Moderate to Severe Plaque Psoriasis	ICD 10 Code: L40.0
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
☐ Moderate to Severe Rheumatoid Arthritis	ICD 10 Code: M06.9
☐ Other: ____________________	ICD 10 Code: ________

Has the patient had failure or contraindication to at least 12 weeks of at lease one DMARD? ☐ Yes ☐ No

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ Labs and Tests supporting primary diagnosis
  *Patient may be required to submit a pregnancy test prior to treatment
- ☐ Clinical/Progress notes supporting primary diagnosis (must be within 1 year)
- ☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody
- ☐ TB Test Results

MEDICATION ORDERS

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

Dosing

Please indicate frequency in black space provided.

- ☐ J0717 Cimzia 400 mg SubQ injection at week 0, 2, and 4, and every 4 weeks thereafter
- ☐ J0717 Cimzia 400 mg SubQ injection at week 0, 2, and 4, and then 200 mg SubQ injection every other week thereafter
- ☐ Other ______________________________

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ **_________ 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

INFUSION ORDERS - CIMZIA (CERTOLIZUMAB)

Clinics Scan to: Physician Orders