LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICDE 10 CODE

☐ Rheumatoid Arthritis (RA)	ICD 10 Code: M05.9
☐ Systemic Juvenile Idiopathic Arthritis (SJIA)	ICD 10 Code: M08320
☐ Other: _____	ICD 10 Code: _____

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

☐ The signed order form by the provider ☐ Patient demographics AND insurance information ☐ Prior authorization with reference number *Pt may be required to submit a pregnancy test prior to treatment	☐ Clinical/Progress notes (must be within 1 year) ☐ labs and tests supporting primary diagnosis ☐ TB test results (within 1 year)

List of tried and failed therapies, including duration of treatment:

1) _____
2) _____

MEDICATION ORDERS

Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____

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

Duration: ☐ x6 months ☐ x 1 year ☐ x _____ doses

PREMEDICATIONS/ LAB ORDERS

☐ Acetaminophen _____mg PO PRN	☐ CBC ☐ prior to each infusion or ☐ Frequency: _____
☐ Benadryl _____mg PO or IV	☐ CMP ☐ prior to each infusion or ☐ Frequency: _____
☐ Other: _____ Date:_____	☐ Other: _____

ADDITIONAL ORDERS/INFORMATION

PRESCRIBER INFORMATION

Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – ORENCIA (ABATACEPT)