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	Diagnosis	ICD 10 Code
☐ Adult-Onset Still's Disease (AOSD)	ICD 10 Code: M06.1	☐ Familial Mediterranean Fever (FMF)	ICD 10 Code: M04.1
☐ Systemic Juvenile Idiopathic Arthritis (SJIA)	ICD 10 Code: M08.20	☐ Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)	ICD 10 Code: M04.1
☐ Cryopyrin-Associated Periodic Syndromes (CAPS)	ICD 10 Code: M04.2		
☐ Hyperimmunoglobulin D Syndrome (HIDS)	ICD 10 Code: M04.1	☐ Gout Flare	ICD 10 Code: M10.9
☐ Mevalonate Kinase Deficiency (MKD)	ICD 10 Code: M04.1	☐ Other: ____________________	ICD 10 Code: ________

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

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
☐ Current Medication List
*Patient 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 (must be within 1 year)
☐ TB Test Results

List Tried & Failed Therapies, including duration of treatment:
1)
2)

MEDICATION ORDERS

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

Diagnosis	Weight	Order
•HIDS •MKD •FMF •TRAPS	≤40kg	☐ J0638 Ilaris 2mg/kg SubQ every 4 weeks ☐ Other: ____________________
	>40kg	☐ J0638 Ilaris 150mg SubQ every 4 weeks ☐ Other: ____________________
•CAPS	≥15kg to <40kg	☐ J0638 Ilaris 2mg/kg SubQ every 8 weeks ☐ Other: ____________________
	>40kg	☐ J0638 Ilaris 150mg SubQ every 8 weeks
•AOSD •SJIA	≥7.5kg	☐ J0638 Ilaris 4mg/kg SubQ (maximum of 400mg) every 4 weeks
•Gout Flare		☐ J0638 Ilaris 150mg SubQ every 12 weeks x ______doses In patients who require re-treatment, there should be an interval of at least 12 weeks before a new dose of Ilaris may be administered.

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ **________ doses**

ADDITIONAL ORDERS /INFORMATION

Lab Orders to be drawn at time of infusion: ____________________ Lab Frequency: ☐ Monthly ☐ Other: ____________

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
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