

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	
<small>*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.</small>			
Diagnosis and ICD 10 CODE			
<input type="checkbox"/> Systemic lupus erythematosus		ICD 10 Code: M32.9	
<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"/> Patient demographics AND insurance information <input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis (must be within 1 year)		<input type="checkbox"/> Current Medication List <input type="checkbox"/> Labs and test supporting primary diagnosis <input type="checkbox"/> ANA, Anti-dsDNA, Anti-Ro/SSA and/or anti-Smith antibodies	
<small>*Patient may be required to submit a pregnancy test prior to treatment</small>			
List Tried & Failed Therapies, including duration of treatment:			
1) Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e. hydroxychloroquine, immunosuppressants, corticosteroids)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2) Has the patient tried and failed Benlysta therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
MEDICATION ORDERS			
Dosing Wt for Calculations		Ht:	Wt (in kg):
		BMI:	
Dosing	<input type="checkbox"/> J0491 Saphnelo 300mg IV every 4 weeks <input type="checkbox"/> Other: _____		
Duration	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses		
PREMEDICATIONS			
<input type="checkbox"/> Tylenol _____ mg PO <input type="checkbox"/> Benadryl _____ mg PO or IV <input type="checkbox"/> Solumedrol _____ mg IV <input type="checkbox"/> Other: _____			
ADDITIONAL ORDERS / INFORMATION			
Lab Orders to be drawn at time of infusion: _____		Lab Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> 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:	<input type="checkbox"/> MATTOON 1000 Health Center Dr. Ph. 217-258-4150 Suite 204 Fax 217-348-2579 Mattoon, IL 61938	<input type="checkbox"/> EFFINGHAM 901 Medical Park Dr. Ph. 217-342-7500 Suite 201 Fax 217-342-7499 Effingham, IL 62401
Fax Completed Form and all documentation to:		