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

☐ Chronic GVHD	ICD 10 Code: D89.811
☐ Acute on Chronic GVHF	ICD 10 Code: D89.812
☐ GVHD, Unspecified	ICD 10 Code: D89.813
☐ Other complications of bone marrow transplant	ICD 10 Code: D89.81
☐ Other: _____	ICD 10 Code: _____

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

☐ This signed order form by the provider	☐ Current Medication List
☐ 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 (must be within 1 year)

Has patient received and failed at least 2 prior treatments (systemic therapy)? ☐ Yes ☐ No

List Tried & Failed Therapies, including duration of treatment:

1)

2)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt: BMI:

☐ J9038 Niktimvo 0.3mg/kg (max 35 mg) every 2 weeks in adults & pediatric patients weighing 40kg and above until progression or unacceptable toxicity

☐ Other: _____

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

PREMEDICATIONS

☐ Tylenol 1000mg PO

☐ Benadryl _____ mg IV or PO

☐ Solumedrol _____ mg IV

☐ Other: _____

ADDITIONAL ORDERS / INFORMATION

Labs: ☐ AST ☐ ALT ☐ ALP ☐ CPK ☐ Amylase ☐ Lipase

Lab Frequency: ☐ Monthly ☐ Other: Every 2 weeks for the first month; and every 1-2 months thereafter _____

Lab to be drawn by: ☐ Infusion Center ☐ Referring Provider

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. Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499

MEDICATION ORDERS - NIKTIMVO (AXATILIMAB-csfr)

Clinics Scan to: Physician Orders