

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	
*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.			
Diagnosis and ICD 10 CODE			
<input type="checkbox"/> Renal Transplant Recipient		ICD 10 Code: Z94.0	
<input type="checkbox"/> Other: _____		ICD 10 Code: _____	
<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"/> Clinical/Progress notes supporting primary diagnosis (must be within 1 year)	
<input type="checkbox"/> Patient demographics AND insurance information		<input type="checkbox"/> TB Test Results	
<input type="checkbox"/> Labs and Tests supporting primary diagnosis		<input type="checkbox"/> EBV Serostatus	
*Patient may be required to submit a pregnancy test prior to treatment			
MEDICATION ORDERS			
Dosing Wt for Calculations		Ht:	Wt (in kg):
		BMI:	
Initial Dosing	<input type="checkbox"/> Nulojix 10mg/kg IV Day 1, Day 5 end of week 2 and week 4 after transplantation, end of weeks 8 and 12 after transplantation		
Maintenance Dosing	<input type="checkbox"/> Nulojix 5mg/kg at end of week 16 after transplantation, then every 4 weeks		
PREMEDICATIONS			
<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg PO <input type="checkbox"/> 650mg PO <input type="checkbox"/> 1000mg PO <input type="checkbox"/> Loratadine (Claritin) 10mg PO <input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg IV <input type="checkbox"/> 125mg IV <input type="checkbox"/> Hydrocortisone (Solu-Cortef) <input type="checkbox"/> 100mg IV <input type="checkbox"/> Other: _____			
Duration	<input type="checkbox"/> X 6 months	<input type="checkbox"/> X 1 year	<input type="checkbox"/> _____ doses
ADDITIONAL ORDERS / INFORMATION			
<input type="checkbox"/> Distribution Number: _____			
<input type="checkbox"/> CBC <input type="checkbox"/> at each dose <input type="checkbox"/> every _____			
<input type="checkbox"/> CMP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____			
<input type="checkbox"/> CRP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____			
<input type="checkbox"/> Micro Albumin Protein/Creatinine Ratio <input type="checkbox"/> at each dose <input type="checkbox"/> every _____			
<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: SBL Infusion Center
Ph. 217-258-4150
217-342-7500
Fax Completed Form and all documentation to: Fax 217-342-7499