

**For new referrals, please include recent labs and last two office visit notes.**

**Fax completed form to (315) 457-4305**

Phone (315) 457-3091

**1. PATIENT INFORMATION**

Name:		DOB:	
Phone:		Other Phone:	
Email:			
Social Security #:		Allergies:	
Gender:	M      F	Weight:	Lbs      Kg
Patient Status:		Next due date (if applicable):	
New to therapy		Continuing therapy	

**2. INSURANCE INFORMATION (required)**

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

**3. PHYSICIAN INFORMATION**

Physician Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State	Zip
Office Contact:		Email:	
Office phone:		Office fax:	

**4. DIAGNOSIS INFORMATION (ICD 10 Code Required)**

Asthma w/type 2 inflammation ≥ 12 years old ( \_\_\_\_\_ )      CRSwNP ≥ 18 years old ( \_\_\_\_\_ )      Other: \_\_\_\_\_

**5. PRESCRIPTION INFORMATION (requires new order every 12 months)**

EXDENSUR	<b>PRE-MEDICATIONS</b>	N/A
Administer 100mg SubQ every 6 months	Acetaminophen	500mg    650mg    1000mg
Vital signs per HI Protocol	Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Anaphylaxis & Hydration Management per HI Protocol	Diphenhydramine (Benadryl)	25mg    50mg    PO    IV (requires driver)
	Methylprednisolone (Solu-Medrol)	40mg    80mg    125mg IV
	Prednisone	_____ mg PO
	Other	_____
	<b>POST-MEDICATIONS</b>	N/A
	Acetaminophen	500mg    650mg    1000mg
	Prednisone	_____ mg PO
	Other	_____

**6. LABS**

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date): _____		
Other (specify): _____		

**7. SIGNATURE (required)**

PHYSICIAN'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_