



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

Fax completed form to (724) 240-1586

Phone (724) 510-3702

1. PATIENT INFORMATION

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

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)

ICD 10 Code ( )

\*\*CMP/CBC/TSH/T4 within last 3 months\*\*

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

KEYTRUDA
200 mg IV every 3 weeks
400 mg IV every 6 weeks
Other:

Vital signs per HI Protocol

Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS N/A
Acetaminophen 500mg 650mg 1000mg
Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)
Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
Prednisone mg PO

Other

POST-MEDICATIONS 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