



Location
Camillus
Liverpool
New Hartford

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: 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)

Pediatrics and Adults with primary hyperoxaluria type 1 (PH1) () Other:

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

Body Weight <10kg Loading Dose: 6mg/kg once monthly for 3 doses Maintenance Dose: 3mg/kg once monthly, beginning 1 month after the last loading dose	PRE-MEDICATIONS N/A Acetaminophen 500mg 650mg 1000mg Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
Body Weight 10kg to <20kg Loading Dose: 6mg/kg once monthly for 3 doses Maintenance Dose: 6mg/kg once every 3 months (quarterly), beginning 1 month after the last loading dose	Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver) Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV Prednisone _____ mg PO Other _____
Body Weight ≥20kg Loading Dose: 3mg/kg once monthly for 3 doses Maintenance Dose: 3mg/kg once every 3 months (quarterly), beginning 1 month after the last loading dose	POST-MEDICATIONS N/A Acetaminophen 500mg 650mg 1000mg Prednisone _____ mg PO Other _____
Vital signs per HI Protocol Anaphylaxis & Hydration Management per HI Protocol	

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