



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)

NMOSD (Neuromyelitis optica spectrum disorder) (_____) **Immunoglobulin G4-related disease (IgG4-RD) (_____)**
AChR or MuSK Ab+ generalized MG (_____) ***Hep B, TB and Ig Levels required before 1st dose**

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

UPLIZNA	PRE-MEDICATIONS	N/A
Initial Maintenance	Acetaminophen	500mg 650mg 1000mg
Initial Dose: 300mg IV, followed 2 weeks later by a second dose of 300mg IV	Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Maintenance (starting 6 months from 1st infusion): 300mg IV Q6 months	Diphenhydramine (Benadryl)	25mg 50mg PO IV (requires driver)
Vital signs per HI protocol	Methylprednisolone (Solu-Medrol)	40mg 80mg 125mg IV
Anaphylaxis & Hydration Management per HI protocol	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