



**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)**

Rheumatoid Arthritis (\_\_\_\_\_)    Ankylosing Spondylitis (\_\_\_\_\_)    Other \_\_\_\_\_ **\*Hep B and TB required prior to initial infusion**  
 Psoriatic Arthritis (\_\_\_\_\_)    Crohn's Disease (\_\_\_\_\_)    \_\_\_\_\_

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

CIMZIA	<b>PRE-MEDICATIONS</b>	N/A
Initial      Maintenance	Acetaminophen	500mg    650mg    1000mg
Administer single 200mg/mL injection every two weeks OR	Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Administer 2 X 200mg/mL injection every four weeks OR	Diphenhydramine (Benadryl)	25mg    50mg    PO    IV (requires driver)
Administer _____	Methylprednisolone (Solu-Medrol)	40mg    80mg    125mg IV
Loading Dose: Administer two (2) 200mg injections at weeks 0, 2, and 4, then _____mg every _____ weeks	Prednisone	_____ mg PO
Vital signs per HI protocol	Other	_____
Anaphylaxis & Hydration Management per HI protocol	<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