Select location:

Akron	Cleveland (North Olmsted)	Liberty	Springfield
Anderson	Columbus (East Broad)	Lima	Toledo
Athens	Columbus (Hilliard)	Mansfield	Troy
Canton	Columbus (Worthington)	Mentor	Warren
Cincinnati (Blue Ash)	Dayton (Beavercreek)	Perrysburg	Youngstown
Cincinnati (West Side)	Dayton (Englewood)	Sandusky	Zanesville
Cleveland (Mayfield)	Findlay	Solon	Crestview Hills (KY)

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

Fax completed form to 888-977-0914

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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*)

Non-Radiographic Axial Spondyloarthritis(______________) Ankylosing Spondylitis (_____________)
Psoriatic Arthritis (_______________) Other: __________________

***Labs: TB within last year required (prior to starting only)**

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

Loading: 6mg/kg IV week 0

Maintenance: 1.75mg/kg IV Q4 weeks (MAX maintenance dose 300mg Q infusion)

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)
Diphenhydrimine (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