



Location

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	PRE-MEDICATIONS	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	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