



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:		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 ( \_\_\_\_\_ )      Other: \_\_\_\_\_      **\*Labs: TB and HBV required prior to starting**  
 Juvenile Idiopathic Arthritis ( \_\_\_\_\_ )

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

ORENCIA	Initial	Maintenance	PRE-MEDICATIONS	N/A
Initial Dose: Administer at week 0, week 2 and week 4			Acetaminophen	500mg      650mg      1000mg
500mg (2 vials)      750mg (3 vials)      1000mg (4 vials)			Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Maintenance Dose: Administer every 4 weeks			Diphenhydramine (Benadryl)	25mg      50mg      PO      IV (requires driver)
500mg (2 vials)      750mg (3 vials)      1000mg (4 vials)			Methylprednisolone (Solu-Medrol)	40mg      80mg      125mg IV
Infuse over 30 minutes <b>OR</b>			Prednisone _____ mg PO	
Infuse at _____			Other _____	
Vital signs per HI Protocol			POST-MEDICATIONS	N/A
Anaphylaxis & Hydration Management per HI Protocol			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 \_\_\_\_\_