



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)

Asthma w/type 2 inflammation ≥ 12 years old ( \_\_\_\_\_ )      CRSwNP ≥ 18 years old ( \_\_\_\_\_ )      Other: \_\_\_\_\_

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

##### EXDENSUR

Administer 100mg SubQ every 6 months

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)  
Diphenhydramine (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