



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)

Alzheimer's Disease (_____) Other: _____

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

Referring provider is responsible for obtaining an MRI prior to infusions #1, #2, #3, #4, and #7.

CMS Registry Letter Received and Attached
Yes No

Registry Trial Number: NCT06058234
Other _____

Administer over approximately 30 minutes Q4 weeks:
 Infusion 1: 350mg
 Infusion 2: 700mg
 Infusion 3: 1050 mg
 Infusion 4 and beyond: 1400mg

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