Location
Camillus
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 (________________)
Juvenile Idiopathic Arthritis (______________)
Other: __________________
***Labs: TB and HBV required prior to starting**

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

ORENCIA Initial Maintenance

Initial Dose: Administer at week 0, week 2 and week 4
500mg (2 vials) 750mg (3 vials) 1000mg (4 vials)

Maintenance Dose: Administer every 4 weeks
500mg (2 vials) 750mg (3 vials) 1000mg (4 vials)

Infuse over 30 minutes *OR*

Infuse at ________________________________

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