



Location

Liverpool
New Hartford

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (315) 457-4305

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)

Paroxysmal nocturnal hemoglobinuria (_____)	Myasthenia Gravis (_____)	*Meningococcal Vaccination Status & Date (must be at least 2 weeks prior to 1st dose)
Atypical hemolytic uremic syndrome (_____)	Other: _____	
NMOSD/AQP4 antibody + (_____)		

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

Initial	Maintenance	PRE-MEDICATIONS	N/A
Administer _____ mg IV every _____ weeks	Followed by _____ mg IV every _____ weeks	Acetaminophen	500mg 650mg 1000mg
Then _____ mg IV every _____ weeks	Infuse at _____	Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Vital signs per HI Protocol	Anaphylaxis & Hydration Management per HI Protocol	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