



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

Fax completed form to (724) 240-1586

Phone (724) 510-3702

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. PRIMARY AND SECONDARY DIAGNOSIS INFORMATION (ICD 10 Code Required)

Table with 3 columns: Primary Diagnosis, Secondary Diagnosis, and ICD 10 Code. Includes codes like Z00.6, G30.0, G30.1, G30.8, G30.9, and G31.84.

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

*Recent baseline brain MRI required prior to initiating treatment
*Referring provider is responsible for obtaining an MRI within approximately one week prior to the 3rd, 5th, 7th, and 14th infusions
Administer 10 mg/kg IV over 1 hour Q2 weeks for 18 months
After 18 months Q2 weeks Q4 weeks
-CMS Registry Letter Received and Attached Yes No Registry Trial #: NCT06058234
Other
Vital signs per HI Protocol
Anaphylaxis & Hydration Mgmt 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