



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: 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)

Severe Asthma (ages 6+) with Eosinophilic Phenotype () EGPA ()
 Chronic Rhinosinusitis with Nasal Polyps () Other ()
 COPD with Eosinophilic Phenotype () HES (ages 12+) without an ID Non-Hematologic 2 Cause ()

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

NUCALA Administer 100mg SubQ every 4 weeks OR Administer _____ 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