



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

Fax completed form to (724) 240-1586

Phone (724) 510-3702

Phone: DOB: 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)

ICD 10 Code ()

CMP/CBC/TSH/T4 within last 3 months

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

YERVOY 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