Upstate HomeCare

The Best for Getting Better

SPECIALTY PRESCRIPTION ORDER

Phone: (877) 286-0800
Fax: (315) 580-4297

Complete or Attach Patient's Demographic Information

Patient Name: _____ Gender: _____ DOB: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Preferred Phone: _____ Alternate Phone: _____
Email Address: _____

Referral Checklist - Please Attach the Following

☐ **Demographics/Insurance** **H&P/Progress Notes/Labs/Medication Profile/Failed Therapies**

Diagnosis Information / Medical Assessment

Diagnosis: _____

Has patient received a PPD (tuberculosis) Skin Test or QuantiFeron TB GOLD Test? ☐ Yes ☐ No Results: _____
Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection.

Prescription Information

Medication: _____ Dose: _____mg/Kg _____mg IV q _____ x 1 year

Medication: _____ Dose: _____ Route: _____ Frequency: _____ Qty: _____ Refills: _____

☐ Sodium Chloride 0.9% 10mL Syringe (Use to flush IV line. #3 with 11 refills)

☐ Other: _____

Labs: ☐ CBC w/differential ☐ ESR ☐ CMP ☐ CRP ☐ Other: _____

Pre-Meds

☐ Sodium Chloride 0.9% 250mL Bag Qty #1 Refills: _____ Route: _____ Directions: _____

☐ Diphenhydramine 50mg/mL 1mL Vial Qty #1 Refills: _____ Route: _____ Directions: _____

☐ Methylprednisolone 40mg Vial Qty #1 Refills: _____ Route: _____ Directions: _____

☐ Other: _____

Anaphylactic Orders:

☐ Epinephrine 1mg/mL Vial #1 (Use in the event of an anaphylactic reaction. Adult dose = 0.3mL **IM**/intramuscularly)

Complete Prescriber Information

Ordering Provider: **Phone:**

NPI#:

Provider Signature: **Date:**

By signing this form, you, as the following physician are authorizing an Upstate HomeCare Pharmacist to transcribe the above order into verbal orders.