

SPECIALTY PRESCRIPTION ORDER

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

Complete or Attach Patient's Demographic Information					
Patient Name:			der:	DOB:	
Street Address:					
City:					
Preferred Phone: Email Address:					
	Checklist - Ple		the Followi	ind	
					ad Theyeniae
Demographics/Insurance	•		abs/Medication		ea inerapies
_	osis Information	•	Assessmen	it	
Diagnosis:					
Has patient received a PPD (tuberculosis) Skin To Prior to initiating treatment and periodically during therapy, patient tested for latent infection.			Yes Results: No		
Prescription Information					
Medication:	Dose:	mg/Kg	mg IV q	x 1 year	
Medication:		Route:	Frequency:	Qty:	Refills:
Sodium Chloride 0.9% 10mL Syringe (Us Other:	se to flush IV line. #3 with	11 refills)			
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 Other:	Qty #1 Refills:	Route:	Directions:		
<u> </u>					
Anaphylactic Orders: Epinephrine 1mg/mL Vial #1 (Use in the event of an anaphylactic reaction. Adult dose = 0.3mL IM /intramuscularly)					
Epinephrine Img/mL viai #1 (Use in the	e event of an anaphylactic	reaction. Adult do	ose = 0.3mL IM /Int	ramusculariy)	
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.

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