

SPECIALTY PRESCRIPTION ORDER

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

Complete or Att	ach Patient'	's Demograpi	nic Information	
Patient Name:		Gender:	DOB:	
Street Address:				
City:			·	
Preferred Phone: Email Address:				
Referral Che	cklist - Plea	ise Attach th	e Following	
Demographics/Insurance	H&P/Progre	ess Notes/Labs/	Medication Profile/I	Failed Therapies
Diagnosis I	Information	/ Medical As	sessment	
Diagnosis:				
Has patient received a PPD (tuberculosis) Skin Test or Querior to initiating treatment and periodically during therapy, patient should be tested for latent infection.			Results:	
	rescription	Information		
Medication:	Dose:		mg/Kg IV every	x 1 year
Medication:	Dose:	Route: e	very	x 1 year
_				/eight:
Sodium Chloride 0.9% 10mL Syringe (Use to flu:	sh IV line before and	d after infusion. #3 w	ith 11 refills) Current W	eignt
Other:				
Labs: CBC w/differential ESR CMP	CRP O	ther:		
	Pre-l	Meds ———		
Sodium Chloride 0.9% 250mL Bag Qty #	‡1 Refills:	Route:	Directions:	
	‡1 Refills:		Directions:	
	#1 Refills:			
Other:				
	Anaphylac			
Epinephrine 1mg/mL Vial #1 (Use in the event	of an anaphylactic r	eaction. Adult dose =	0.3mL IM /intramuscular	y)
Comp	plete Prescr	iber Informat	tion	
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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