



# Quzyttir Order Form

Select patient referral location:  Akron  Blue Ash  Cleveland  Columbus  Crestview Hills  Springfield  West Cincinnati  
 Other \_\_\_\_\_

Fax completed form to 888-977-0914. For new referrals, please **include recent labs and last two office visit notes.**

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### 1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

### 2. PHYSICIAN INFORMATION

Physician's name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

### 3. DIAGNOSIS INFORMATION (and year of diagnosis)

Acute Urticaria (ICD 10 \_\_\_\_\_)  
 Other (specify): \_\_\_\_\_

### 4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

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

#### QUZYTTR

Adults/Adolescents ≥ 12 years of age  
 10 mg IVP over 1-2 minutes once Q 24 hours

Children 6-11 years of age  
 5 mg IVP  
 10 mg IVP

Vital signs per HI Protocol  
 Anaphylaxis & Hydration Management per HI Protocol

#### PRE-MEDICATIONS N/A

Acetaminophen  500mg  650mg  1000mg PO  
 Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)  
 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 PO  
 Prednisone \_\_\_\_\_ mg PO  
 Other: \_\_\_\_\_

### 6. LABS

<input type="checkbox"/> CBC w/Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): _____		
<input type="checkbox"/> Other (specify): _____		

### 7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE