



Select location:

Akron	Cleveland (Mayfield)	Dayton (Englewood)	Springfield
Anderson	Cleveland (North Olmsted)	Findlay	Toledo
Athens	Columbus (East Broad)	Liberty	Troy
Canton	Columbus (Hilliard)	Mansfield	Warren
Cincinnati (Blue Ash)	Columbus (Worthington)	Mentor	Youngstown
Cincinnati (West Side)	Dayton (Beavercreek)	Perrysburg	Zanesville
		Sandusky	Crestview Hills (KY)

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

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:		DOB:	
Phone:		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. PRIMARY AND SECONDARY DIAGNOSIS INFORMATION (ICD 10 Code Required)

Primary Diagnosis	Secondary Diagnosis	
Z00.6 Encounter for examination for normal comparison and control in clinical research program	G30.0 Alzheimer's disease w/early onset	G30.8 Other Alzheimer's disease
	G30.1 Alzheimer's disease w/late onset	G30.9 Alzheimer's disease, unspecified
		G31.84 Mild cognitive impairment, unknown etiology

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

*Recent baseline brain MRI required prior to initiating treatment *Referring provider is responsible for obtaining an MRI within approximately one week prior to the 3rd, 5th, 7th, and 14th infusions Administer 10 mg/kg IV over 1 hour Q2 weeks for 18 months After 18 months Q2 weeks Q4 weeks -CMS Registry Letter Received and Attached Yes No Registry Trial #: _____ Vital signs per HI Protocol Anaphylaxis & Hydration Mgmt per HI Protocol	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