Horizon Infusions

Tezspire Order Form

Select patient referral location: **Akron**   **Athens**   **Blue Ash**   **Cleveland**   **Columbus**   **Crestview Hills**

Dayton   **Mansfield**   **Perrysburg**   **Springfield**   **Toledo**   **West Cincinnati**

Fax completed form to 888-977-0914. For new referrals, please __include recent labs and last two office visit notes.__
Toll Free Phone: 877-787-8720   •   www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Home 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. 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)*

☐ Severe Asthma (**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)*

TEZSPIRE

☐ Administer 210 mg SubQ every 4 weeks

☐ 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

☐ 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