



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:		Next due date (if applicable):	
New to therapy		Continuing therapy	

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. DIAGNOSIS INFORMATION (ICD 10 Code Required)

Alzheimer's Disease ()

Other: _____

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

Referring provider is responsible for obtaining an MRI prior to infusions #1, #2, #3, #4, and #7.

CMS Registry Letter Received and Attached

Yes No

Registry Trial Number: _____

Administer over approximately 30 minutes Q4 weeks:

Infusion 1: 350mg

Infusion 2: 700mg

Infusion 3: 1050 mg

Infusion 4 and beyond: 1400mg

Vital signs per HI protocol

Anaphylaxis & Hydration Management 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