



Quzyttir Order Form

Select patient referral location: Akron Athens Blue Ash Cleveland Columbus Crestview Hills
Dayton Mansfield Perrysburg Springfield Toledo West Cincinnati

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. DIAGNOSIS INFORMATION (and year of diagnosis) *TB required prior to initial infusion

Acute Urticaria(_____) ICD 10 (_____) Other: _____

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

QUZYTIR

Adults/Adolescents $\geq$ 12 years of age
10mg IVP over 1-2 minutes once Q 24 hours
Children 6-11 years of age
5mg IVP
10mg IVP

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