Infliximab

Horizon Infusions

Location
- ☐ Camillus
- ☐ Liverpool
- ☐ New Hartford

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

Fax completed form to (315) 457-4305
Phone (315) 457-3091

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 (ICD 10 Code *Required*) - Hep B and TB required prior to initial infusion

☐ Rheumatoid Arthritis (_____) ☐ Ankylosing Spondylitis (_____) ☐ Plaque Psoriasis (_____)
☐ Psoriatic Arthritis (_____) ☐ Crohn's Disease (_____) ☐ Ulcerative Colitis (_____) ☐ Other: _____

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

☐ Use preferred Infliximab product per payer recommendations

☐ Product name: _____ _____ _____
To be completed by Horizon Infusions Horizon Clinical Signature Dated

Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg
☐ Other:_____
☐ Round up to nearest 100mg OR ☐ Give exact dose
(If not indicated, will round)

Frequency: ☐ Induction: week 0, 2, 6, and then every 8 wks
☐ Maintenance: every 8 weeks ☐ other: _____

Infusion Rate: Select one below. Patients who tolerate induction and the initial maintenance infusion without severe reaction will be eligible for 1 hour infusion
☐ Infuse over 2 hours (standard rate)
☐ Infuse over 1 hour (when patient eligible)

☐ Vitals and Anaphylaxis 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*): _____

☐ Quantiferon TB Gold, annually, last completed *(date)*: _____
☐ Other (*specify*):_____

7. SIGNATURE (required)

_____ _____
PHYSICIAN'S SIGNATURE **DATE**