

Patient Status: ☐ NEW* ☐ CONTINUING

Next Due Date (if applicable) _____ Choose Location _____

*Include recent labs and last 2 office visit notes

Name _____ DOB _____

Phone _____ Other Phone _____

Email _____ SSN _____

Allergies _____ Weight _____ ☐ LBS ☐ Kg Gender ☐ M ☐ F

INSURANCE INFORMATION (Required)

Submit copies of the front and back of primary and/or secondary insurance cards with this referral

Physician Name _____ NPI# _____

License # _____ TIN# _____ DEA# _____

Address _____

City _____ State _____ Zip _____

Office Contact _____ Email _____

Phone _____ Fax _____

DIAGNOSIS INFORMATION:

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

Required Labs: Hep B and TB required prior to initial infusion

DOSING

☐ Use preferred Infliximab product per payer recommendations

☐ Product name: _____

To be completed by Horizon Infusions

Dose ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg

☐ Other _____

Round up to the 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 _____

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): _____

Provider Signature _____

Date _____

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

Fax Referrals to: Kentucky (888) 977-0914 | New York (315) 457-4305 | Ohio (888) 977-0914 | Pennsylvania (724) 240-1586