

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:

☐ Type 1 diabetes mellitus with unspecified complications _____

☐ Type 1 diabetes mellitus without complications _____

☐ Other _____

DOSING

☐ Infuse Tziel IV daily for 14 days according to the below dosing regimen:

- Day 1: 65 mcg/m²
- Day 2: 125 mcg/m²
- Day 3: 250 mcg/m²
- Day 4: 500 mcg/m²
- Day 5 through 14: 1,030 mcg/m²

☐ 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 _____

*LABS

☐ Baseline CBC & LFTs (required)

Baseline hold parameters: Lymphocyte count <1,000/mcL, Hgb <10g/dL, Platelets <150,000/mcL, ANC <1,500/mcL, ALT/AST >2x ULN, or bilirubin >1.5x ULN

☐ Repeat CBC & LFTs every _____ day(s)

Notify physician for abnormal labs.

Discontinue treatment for AST/ALT >5x ULN or bilirubin > 3x ULN

Discontinue treatment for prolonged lymphopenia (<500/mcL) lasting 1 week or longer

Required labs to be drawn by:

☐ Horizon Infusions

☐ Referring physician

- ☐ 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