Horizon Infusions

Glassia [Alpha$_1$-Proteinase Inhibitor]

Select location:

- ☐ Akron
- ☐ Anderson
- ☐ Athens
- ☐ Canton
- ☐ Cincinnati (Blue Ash)
- ☐ Cincinnati (West Side)
- ☐ Cleveland (Mayfield)
- ☐ Cleveland (North Olmsted)
- ☐ Columbus (East Broad)
- ☐ Columbus (Hilliard)
- ☐ Columbus (Worthington)
- ☐ Dayton (Beavercreek)
- ☐ Dayton (Englewood)
- ☐ Findlay
- ☐ Liberty
- ☐ Mansfield
- ☐ Mentor
- ☐ Perrysburg
- ☐ Sandusky
- ☐ Springfield
- ☐ Toledo
- ☐ Troy
- ☐ Warren
- ☐ Youngstown
- ☐ Zanesville
- ☐ 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: ☐ 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*)

☐ Emphysema (_____) ☐ Alpha Antitrypsin Deficiency (_____) ☐ Other: _____

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

☐ ARALAST ☐ GLASSIA

Administer 60mg/kg IV once per week

☐ PROLASTIN-C

Administer 60mg/kg (+/- 10%) IV once per week

☐ 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)
- ☐ Diphenhydrimine (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**