Select location:

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

Generalized Myasthenia Gravis (_______) CIDP (_______) Other: _________________

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

Generalized Myasthenia Gravis (gMG)

Dosing: 1008 mg efgartigimod alfa/11200 units hyaluronidase SQ Weekly x4 weeks (one treatment cycle)

Select for additional treatment cycles. _________ (Indicate number of cycles)

- Subsequent cycles may require additional insurance authorization.
- Treatment cycles will be given 50 days from the start of the previous treatment cycle.

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

Dosing: 1008 mg efgartigimod alfa/11200 units hyaluronidase SQ Weekly

Vital signs per HI Protocol

Anaphylaxis & Hydration Management per HI

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