

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: | | Next due date (if applicable): | |
| New to therapy Continuing therapy | | | |

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 | PRE-MEDICATIONS | N/A |
| Administer 60mg/kg IV once per week | | Acetaminophen | 500mg 650mg 1000mg |
| | | Fexofenadine (Allegra) | 180mg PO (or other non-sedating antihistamine) |
| PROLASTIN-C | | Diphenhydramine (Benadryl) | 25mg 50mg PO IV (requires driver) |
| Administer 60mg/kg (+/- 10%) IV once per week | | Methylprednisolone (Solu-Medrol) | 40mg 80mg 125mg IV |
| | | Prednisone | _____ mg PO |
| Vital signs per HI Protocol | | Other | _____ |
| Anaphylaxis & Hydration Management per HI Protocol | | 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 _____