Horizon Infusions

Uplizna Order Form

Select patient referral location: ☐ Akron ☐ Athens ☐ Blue Ash ☐ Cleveland ☐ Columbus ☐ Crestview Hills ☐ Dayton ☐ Mansfield ☐ Perrysburg ☐ Springfield ☐ Toledo ☐ West Cincinnati

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 (*and year of diagnosis*)

☐ **NMOSD (Neuromyelitis optica spectrum disorder) (_____)**
***Hep B, TB and Ig Levels required before 1st dose**

☐ **ICD 10**
☐ **Other: _____**

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

UPLIZNA

☐ **Initial** ☐ **Maintenance**

☐ **Initial Dose: 300mg IV, followed 2 weeks later by a second dose of 300mg IV**

☐ **Maintenance (starting 6 months from 1st infusion): 300mg IV Q6 months**

☐ **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**