

Select location:

Akron	Cleveland (North Olmsted)	Liberty	Springfield
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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:		Allergies:	
Social Security #:		Weight: Lbs Kg	
Gender: M F	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)

Active Stills Disease (_____) **Periodic Fever Syndromes** (_____) **Other:** _____
Gout Flares (_____)

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

<p>For Stills Disease, including Adult Onset Stills Disease and Systemic Juvenile Idiopathic Arthritis: 4mg/kg (max of 300mg) weight ≥ 7.5kg SQ Q 4 weeks</p> <p>For Cryopyrin-Associated Periodic Syndromes (CAPS): 150mg weight > 40kg SQ Q 8 weeks 2mg/kg weight ≥ 15kg and ≤ 40kg SQ Q 8 wks</p> <p>For Gout flares: 150mg SQ. In patients who require re-treatment, there should be an interval of at least 12 weeks before a new dose can be administered</p>	<p>For Tumor Necrosis Factor Receptor Associated Periodic Syndrome, Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency, Familial Mediterranean Fever: Weight ≤ 40kg 2mg/kg SQ Q 4 weeks 4 mg/kg SQ Q 4 weeks - consider if clinical response not adequate Weight > 40kg 150mg SQ Q 4 weeks 300mg SQ Q 4 weeks - consider if clinical response not adequate</p> <p>Vital signs per HI protocol Anaphylaxis & hydration management per HI protocol</p>
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6. PRE AND POST MEDICATIONS**PRE-MEDICATIONS**

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

Acetaminophen 500mg 650mg 1000mg
Prednisone _____ mg PO
Other _____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE _____

DATE _____