



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:		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)

Psoriatic Arthritis () Other: _____ *Labs: TB within last year (prior to starting only)

Psoriasis ()

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

RHEUMATOLOGY/DERMATOLOGY STELARA

≤ 100kg: 45mg administered subcutaneously initially and 4 weeks later, followed by 45mg administered subcutaneously every 12 weeks

> 100kg: 90mg administered subcutaneously initially and 4 weeks later, followed by 90mg administered subcutaneously every 12 weeks

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)		
Diphenhydramine (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