



**Select location:**

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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**

<b>Name:</b>		<b>DOB:</b>	
<b>Phone:</b>		<b>Other Phone:</b>	
<b>Email:</b>			
<b>Social Security #:</b>		<b>Allergies:</b>	
<b>Gender:</b>	<b>M</b> <b>F</b>	<b>Weight:</b>	<b>Lbs</b> <b>Kg</b>
<b>Patient Status:</b>		<b>Next due date (if applicable):</b>	
<input type="checkbox"/> New to therapy <input type="checkbox"/> 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**

<b>Physician Name:</b>		<b>NPI#:</b>	
<b>License #:</b>	<b>TIN#:</b>	<b>DEA#:</b>	
<b>Address:</b>			
<b>City:</b>		<b>State</b>	<b>Zip</b>
<b>Office Contact:</b>		<b>Email:</b>	
<b>Office phone:</b>		<b>Office fax:</b>	

**4. DIAGNOSIS INFORMATION (ICD 10 Code Required)**

Multiple Sclerosis ( \_\_\_\_\_ )    Other ( \_\_\_\_\_ )

**\*Labs: Hep B and Baseline IgG levels required prior to initial infusion**

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

Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq)

Administer 920mg SQ in the abdomen over approx. 10 min Q6 months

\*Monitor one hour after the initial injection and for 15 minutes after subsequent injections

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