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: 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*)

Generalized Myasthenia Gravis (gMG) (___________) Other ______________________________

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

Dosing: SQ infusion once weekly x 6 weeks

Body Weight of Patient	Dose
Less than 50 kg	420 mg
50 kg to less than 100 kg	560 mg
100 kg and above	840 mg

Administer subsequent treatment cycles based on clinical evaluation; no sooner than 63 days from the start of the previous treatment cycle.

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