



Select location:

Cincinnati (West Side)

Akron Cleveland (Mayfield) Anderson **Cleveland (North Olmsted) Athens** Columbus (East Broad) Canton Columbus (Hilliard) Cincinnati (Blue Ash) Columbus (Worthington)

Dayton (Englewood) **Springfield Findlay** Toledo Liberty Troy Mansfield Warren **Mentor** Youngstown **Perrysburg** Zanesville

Crestview Hills (KY)

Dayton (Beavercreek) Sandusky For new referrals, please include recent labs and last two office visit notes

Fax completed form to 888-977-0914

DOB: DOB: Property		Phone: 877-787	′-8720 • wv	/w.horizoninfi	usions.com			
Dither Phone:	1. PATIENT INFORMATION							
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) Plasses submit captes of the front and back of primary and/or secondary insurance cards with this referral. 3. PHYSICIAN INFORMATION (required) Physician Name: NPI#:	Name:		D	OB:				
Social Security #: Gender: M F Weight: Lbs Kg Patient Status: New to therapy Continuing therapy Next due date (if applicable): 2. INSURANCE INFORMATION (requires) Plases which topies of the front and back of primary and/or secondary insurance cards with this referral. 3. PHYSICIAN INFORMATION Physician Name: License #: TIN#: DEA#: Address: City: State Zip Office Contact: Office fontact: Office fontact: Office fontact: Office fontact: Office fontact: Initial Maintenance Initial Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer Zmg/kg V over 30 minutes at week 0 and 4; then every 8 weeks thereaf	Phone:		0	her Phone:				
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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) Rheumatoid Arthritis (· · · · · · · · · · · · · · · · · · ·					h- V-		
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3. PHYSICIAN INFORMATION Physician Name: License #: TIN#: DEA#: Address: City: State Zip Office Contact: Email: Office phone: Office fax: 4. DIAGNOSIS INFORMATION (ICD 10 Code Required) Rheumatoid Arthritis (and/or secon	dary insurance	a cards with t	his referral		
License #: TIN#: DEA#: Address: City: State Zip Office Contact: Office Phone: 4. DIAGNOSIS INFORMATION (ICD 10 Code Required) Rheumatoid Arthritis (*		and/or secon	aary maarane	c carus with t	ma referrat.		
License #: TIN#: DEA#: Address: City: State Zip Office Contact: Email: Office phone: Office fax: 4. DIAGNOSIS INFORMATION (ICD 10 Code Required) Rheumatoid Arthritis () Other:*TB within last year and ANNUALLY **HBV prior to starting; 1x occurrence unless HBV carrier 5. PRESCRIPTION INFORMATION (requires new order every 12 months) Initial Maintenance Initial Dose: Administer Zmg/kg IV over 30 minutes at week 0 and 4; then every 8 weeks thereafter Maintenance Dose: Administer mg at mg/kg IV every week(s) Vital signs per HI Protocol Anaphylaxis & Hydration Management per HI Protocol Anaphylaxis & Hydration Management per HI Protocol Anaphylaxis & Hydration Management per HI Protocol CBC w/Diff	Physician Name:		NP	l#:				
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