

**Select location:**

Akron	Cleveland (Mayfield)	Dayton (Englewood)	Springfield
Anderson	Cleveland (North Olmsted)	Findlay	Toledo
Athens	Columbus (East Broad)	Liberty	Troy
Canton	Columbus (Hilliard)	Mansfield	Warren
Cincinnati (Blue Ash)	Columbus (Worthington)	Mentor	Youngstown
Cincinnati (West Side)	Dayton (Beavercreek)	Perrysburg	Zanesville
		Sandusky	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)

Plaque Psoriasis () Other: ***Labs: TB within last year (prior to starting only)**

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

ILUMYA

Initial Dose: Administer 100mg SubQ at weeks 0 and 4

Maintenance Dose: Administer 100mg SubQ 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