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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 and ICD 10 CODE

Neuropathic hereditary amyloidosis E85.1 Organ-limited amyloidosis E85.4
 Wild-type transthyretin-related (ATTR) amyloidosis E85.82

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

AMVUTTRA	PRE-MEDICATIONS	N/A
25mg Sub-Q once every 3 months	Acetaminophen	500mg 650mg 1000mg
Vital signs per HI Protocol	Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Anaphylaxis & Hydration Management per HI Protocol	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 _____