



Select location:

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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)

Paroxysmal nocturnal hemoglobinuria (_____)	Myasthenia Gravis (_____)	*Meningococcal Vaccination Status & Date (must be at least 2 weeks prior to 1st dose) _____
Atypical hemolytic uremic syndrome (_____)	Other: _____	

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

Initial	Maintenance	PRE-MEDICATIONS	N/A
Administer _____ mg IV every _____ weeks	Followed by _____ mg IV every _____ weeks	Acetaminophen	500mg 650mg 1000mg
Then _____ mg IV every _____ weeks	Infuse at _____	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	_____
Vital signs per HI Protocol		POST-MEDICATIONS	N/A
Anaphylaxis & Hydration Management per HI Protocol		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