Select location:

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

Thyroid Eye Disease(________________) Other: __________________ ***Baseline hearing test required**

5. PRESCRIPTION INFORMATION (*requires new order every 12 months*) *Free T3, T4 and CAS required prior to initial infusion

TEPEZZA Initial Maintenance

Initial Dose: Administer ______ mg at 10mg/kg at week 0

Maintenance Dose: Administer Q3 weeks; ______ mg at 20mg/kg x 7 infusions

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)
Diphenhydrimine (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