



**Select location:**

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Cleveland (Mayfield)	Findlay	Solon	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**

<b>Name:</b>		<b>DOB:</b>	
<b>Phone:</b>		<b>Other Phone:</b>	
<b>Email:</b>			
<b>Social Security #:</b>		<b>Allergies:</b>	
<b>Gender:</b>	<b>M</b> <b>F</b>	<b>Weight:</b>	<b>Lbs</b> <b>Kg</b>
<b>Patient Status:</b> <b>New to therapy</b> <b>Continuing therapy</b> <b>Next due date (if applicable):</b>			

**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**

<b>Physician Name:</b>		<b>NPI#:</b>	
<b>License #:</b>	<b>TIN#:</b>	<b>DEA#:</b>	
<b>Address:</b>			
<b>City:</b>		<b>State</b>	<b>Zip</b>
<b>Office Contact:</b>		<b>Email:</b>	
<b>Office phone:</b>		<b>Office fax:</b>	

**4. DIAGNOSIS INFORMATION (ICD 10 Code Required)**

Severe Asthma ( \_\_\_\_\_ )      Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) ( \_\_\_\_\_ )      Other: \_\_\_\_\_

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

<b>TEZSPIRE</b>	<b>PRE-MEDICATIONS</b>	<b>N/A</b>
<b>Administer 210mg SubQ every 4 weeks</b>	Acetaminophen    500mg    650mg    1000mg	
<b>Vital signs per HI Protocol</b>	Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)	
<b>Anaphylaxis &amp; Hydration Management per HI Protocol</b>	Diphenhydramine (Benadryl)    25mg    50mg    PO    IV (requires driver)	
	Methylprednisolone (Solu-Medrol)    40mg    80mg    125mg IV	
	Prednisone _____ mg PO	
	Other _____	
	<b>POST-MEDICATIONS</b>	<b>N/A</b>
	Acetaminophen    500mg    650mg    1000mg	
	Prednisone _____ mg PO	
	Other _____	

**6. LABS**

<b>CBC w/Diff</b>	<b>Each Infusion</b>	<b>Other Frequency (specify):</b> _____
<b>CRP</b>	<b>Each Infusion</b>	<b>Other Frequency (specify):</b> _____
<b>CMP</b>	<b>Each Infusion</b>	<b>Other Frequency (specify):</b> _____
<b>ESR</b>	<b>Each Infusion</b>	<b>Other Frequency (specify):</b> _____
<b>Hepatic Panel</b>	<b>Each Infusion</b>	<b>Other Frequency (specify):</b> _____
<b>Renal Panel</b>	<b>Each Infusion</b>	<b>Other Frequency (specify):</b> _____
<b>Quantiferon TB Gold, annually, last completed (date):</b> _____		
<b>Other (specify):</b> _____		

**7. SIGNATURE (required)**

PHYSICIAN'S SIGNATURE

DATE