



Select location:

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Canton	Columbus (Worthington)	Mentor	Warren
Cincinnati (Blue Ash)	Dayton (Beavercreek)	Perrysburg	Youngstown
Cincinnati (West Side)	Dayton (Englewood)	Sandusky	Zanesville
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

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)

Kidney Transplant () Other: *EBV seropositive patients only*

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

NULOJIX	Initial	Maintenance	PRE-MEDICATIONS	N/A
Day 1 (day of transplantation, prior to implantation) and Day 5 (approximately 96 hrs after Day 1 dose) administer 10 mg/kg IV			Acetaminophen 500mg 650mg 1000mg	
Week 2 and Week 4 after transplantation administer 10mg/kg IV			Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)	
Week 8 and Week 12 after transplantation administer 10mg/kg IV			Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)	
Maintenance Phase			Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV	
End of Week 16 after transplantation administer 5mg/kg IV			Prednisone _____ mg PO	
Every 4 weeks (+/- 3 days) thereafter administer 5mg/kg IV			Other _____	
Vital signs per HI Protocol			POST-MEDICATIONS	N/A
Anaphylaxis and 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