



**Select location:**

Akron	Cleveland (North Olmsted)	Liberty	Springfield
Anderson	Columbus (East Broad)	Lima	Toledo
Athens	Columbus (Hilliard)	Mansfield	Troy
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**

<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>Next due date (if applicable):</b>	
<input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy			

**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)**

Panlobular Emphysema (\_\_\_\_\_)    Alpha1 Antitrypsin Deficiency (\_\_\_\_\_)    Other: \_\_\_\_\_  
 AAT Phenotype/Genotype    PiZZ    PiZ (null)    Pi (null, null)    PiSZ    Other: \_\_\_\_\_  
 Serum AAT Level \_\_\_\_\_ mg/DL or \_\_\_\_\_ µM

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

<b>PROLASTIN-C</b>	<b>PRE-MEDICATIONS</b>	N/A
Administer 60mg/kg (+/- 10%) IV once per week	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	_____
	<b>POST-MEDICATIONS</b>	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 \_\_\_\_\_