



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

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

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

4. DIAGNOSIS INFORMATION (ICD 10 Code Required)

Rheumatoid Arthritis (_____) Other: _____
 *TB within last year and ANNUALLY
 *HBV prior to starting; 1x occurrence unless HBV carrier

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

<p>Initial Maintenance</p> <p>Initial Dose: Administer 2mg/kg IV over 30 minutes at week 0 and 4; then every 8 weeks thereafter</p> <p>Maintenance Dose: Administer _____ mg at _____ mg/kg IV every _____ week(s)</p> <p>Vital signs per HI Protocol</p> <p>Anaphylaxis & Hydration Management per HI Protocol</p>	<p>PRE-MEDICATIONS N/A</p> <p>Acetaminophen 500mg 650mg 1000mg</p> <p>Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)</p> <p>Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)</p> <p>Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV</p> <p>Prednisone _____ mg PO</p> <p>Other _____</p> <p>POST-MEDICATIONS N/A</p> <p>Acetaminophen 500mg 650mg 1000mg</p> <p>Prednisone _____ mg PO</p> <p>Other _____</p>
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6. LABS

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

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE _____

DATE _____