



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)

Chronic Gout (_____) ***Serum Uric Acid (SUA) and G6PD required for referral** Other: _____

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

KRYSTEXXA

Administer 8mg every 2 weeks IV

Horizon Infusions MD will prescribe and manage Immunomodulation Therapy ***See below for required labs**

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)
 Diphenhydramine (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 (<i>specify</i>): _____
CMP	Each Infusion	Other Frequency (<i>specify</i>): _____
Hepatitis B	Each Infusion	Other Frequency (<i>specify</i>): _____
Quantiferon TB Gold	Each Infusion	Other Frequency (<i>specify</i>): _____
Folate	Each Infusion	Other Frequency (<i>specify</i>): _____
CRP	Each Infusion	Other Frequency (<i>specify</i>): _____
ESR	Each Infusion	Other Frequency (<i>specify</i>): _____
Hepatic Panel Renal Panel	Each Infusion	Other Frequency (<i>specify</i>): _____
Other (<i>specify</i>):	Each Infusion	Other Frequency (<i>specify</i>): _____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE _____

DATE _____