Horizon Infusions

# Subcutaneous Immunoglobulin Order Form

Select patient referral location: ☐ Akron ☐ Athens ☐ Blue Ash ☐ Cleveland ☐ Columbus ☐ Crestview Hills ☐ Dayton ☐ Mansfield ☐ Perrysburg ☐ Springfield ☐ Toledo ☐ West Cincinnati

**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 (*and year of diagnosis*)

☐ CVID (_____) ☐ Dermatomyositis (_____) ☐ ICD 10

☐ PI (_____) ☐ Other: _____

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

☐ Immunoglobulin _____
Administer _____ gm at _____ mg/kg every _____ weeks

☐ Hyqvia Immunoglobulin with Recombinant Human Hyalurondase
Administer _____ gm at _____ mg/kg every _____ week(s)

Needle length and infusion site per Horizon protocol

Needle length: ☐ 9mm ☐ 12mm ☐ 14mm

Infusion Site: ☐ Abdomen ☐ Upper Thigh

☐ 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)

☐ Diphenhydrimine (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 (*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**