



Select location:

Akron	Cleveland (Mayfield)	Dayton (Englewood)	Springfield
Anderson	Cleveland (North Olmsted)	Findlay	Toledo
Athens	Columbus (East Broad)	Liberty	Troy
Canton	Columbus (Hilliard)	Mansfield	Warren
Cincinnati (Blue Ash)	Columbus (Worthington)	Mentor	Youngstown
Cincinnati (West Side)	Dayton (Beavercreek)	Perrysburg	Zanesville
		Sandusky	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)

Paroxysmal nocturnal hemoglobinuria (_____)	Meningococcal Vaccination Status & Date _____	Other: _____
Atypical hemolytic uremic syndrome (_____)		
gMG/AChR antibody + (_____)	NMOSD/AQP4 antibody + (_____)	

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

Initial	PRE-MEDICATIONS	N/A
Administer _____ mg Q _____ week(s) IV	Acetaminophen 500mg 650mg 1000mg	
Maintenance	Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)	
Administer _____ mg Q _____ week(s) IV	Diphenhydramine (Benadryl) 25mg 50mg PO	
Vital signs per HI Protocol	Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV	
Anaphylaxis & Hydration Management per HI Protocol	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