



Fasenra Order Form

Select patient referral location: Akron Blue Ash Cleveland Columbus Crestview Hills Springfield West Cincinnati
 Other _____

Fax completed form to 888-977-0914. For new referrals, please **include recent labs and last two office visit notes.**

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

2. PHYSICIAN INFORMATION

Physician's name:	NPI#:
License #: _____ TIN#: _____	DEA#:
Address:	
City:	State: _____ Zip: _____
Office contact:	Email:
Office phone:	Office fax:

3. DIAGNOSIS INFORMATION (and year of diagnosis)

Severe Asthma (_____) Allergic Asthma (_____) Eosinophilic Asthma (_____) CIU (_____) ICD 10 (_____) Other (specify): _____

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

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

FASENRA	PRE-MEDICATIONS <input type="checkbox"/> N/A
<input type="checkbox"/> Administer 30mg q 4 weeks for first 3 doses, followed by 30mg once q 8 weeks, OR	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
<input type="checkbox"/> Administer _____	<input type="checkbox"/> Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
<input type="checkbox"/> Vital signs per HI protocol	<input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> PO <input type="checkbox"/> IV (requires driver)
<input type="checkbox"/> Anaphylaxis and hydration management per HI protocol	<input type="checkbox"/> Methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg <input type="checkbox"/> 80mg <input type="checkbox"/> 125mg IV
	<input type="checkbox"/> Prednisone _____ mg PO
	<input type="checkbox"/> Other: _____
	POST-MEDICATIONS <input type="checkbox"/> N/A
	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
	<input type="checkbox"/> Prednisone _____ mg PO
	<input type="checkbox"/> Other: _____

6. LABS

<input type="checkbox"/> CBC w/Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): _____		
<input type="checkbox"/> Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE _____ DATE _____