Horizon Infusions

Infliximab Order Form

Select referral location:

- ☐ Akron
- ☐ Athens
- ☐ Cincinnati (Blue Ash)
- ☐ Cincinnati (West)
- ☐ Cleveland
- ☐ Columbus (East Broad)
- ☐ Columbus (Hilliard)
- ☐ Columbus (Worthington)
- ☐ Dayton (Beavercreek)
- ☐ Dayton (Englewood)
- ☐ Findlay
- ☐ Liberty
- ☐ Mansfield
- ☐ Perrysburg
- ☐ Springfield
- ☐ Toledo
- ☐ Crestview Hills (NKY)

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*) - Hep B and TB required prior to initial infusion

- ☐ Rheumatoid Arthritis (_____)
- ☐ Psoriatic Arthritis (_____)
- ☐ Ankylosing Spondylitis (_____)
- ☐ Crohn's Disease (_____)
- ☐ Plaque Psoriasis (_____)
- ☐ Ulcerative Colitis (_____)
- ☐ ICD 10
- ☐ Other: _____

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

☐ Use preferred Infliximab product per payer recommendations

☐ Product name: _____
To be completed by Horizon Infusions

_____ Horizon Clinical Signature

_____ Dated

☐ Loading Dose
Administer _____mg OR _____mg/kg at week 0, week 2, and week 6

☐ Maintenance
Administer _____mg OR _____mg/kg IV every ____ weeks

☐ May be rounded up to vial size infused over 2 hours, OR infuse at _____

☐ Vital signs per HI protocol

☐ Anaphylaxis and 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**