Horizon Infusions

Gastroenterology Stelara 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*)

☐ Crohn's Disease (_____)

☐ ICD 10

☐ Other: _____

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

STELARA

☐ Initial ☐ Maintenance

☐ Initial Dose: Administer _____mg IV over one (1) hour

OR

☐ Infuse at _____

Therefore administer maintenance dose:

☐ SQ 90mg every eight (8) weeks ***OR***

☐ Administer at _____

☐ 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**