Horizon Infusions

Rheumatology/Dermatology Stelara 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: ☐ M ☐ F	Weight: ☐ Lbs ☐ Kg
Patient Status: ☐ New to therapy ☐ Continuing therapy	☐ 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)*

☐ Psoriasis (_____) ☐ Psoriatic Arthritis (_____) ☐ **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)*

RHEUMATOLOGY/DERMATOLOGY STELARA

☐ ≤ 100kg: 45mg administered subcutaneously initially and 4 weeks later, followed by 45mg administered subcutaneously every 12 weeks

☐ > 100kg: 90mg administered subcutaneously initially and 4 weeks later, followed by 90mg administered subcutaneously every 12 weeks

☐ Vital signs per HI Protocol

☐ Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ Fexofenadine (Allegra) 180mg PO *(or other non-sedating anti-histamine)*

☐ Diphenhydramine (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 PO

☐ 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