Enzyme Replacement Therapy 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)*

Type I Gaucher Disease (_____) Fabry Disease (_____) Psoriasis (_____) ICD 10 (______) Other: _______________

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

CEREZYME
Administer 60U/kg IV Q 2 weeks *OR*
Administer _______________________________

LUMIZYME
Administer 20mg/kg IV Q 2 weeks *OR*
Administer _______________________________

FABRAZYME
Administer 1mg/kg IV Q 2 weeks *OR*
Administer _______________________________

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