Select location:

Akron
Anderson
Athens
Canton
Cincinnati (Blue Ash)
Cincinnati (West Side)
Cleveland (Mayfield)
Cleveland (North Olmsted)
Columbus (East Broad)
Columbus (Hilliard)
Columbus (Worthington)
Dayton (Beavercreek)
Dayton (Englewood)
Findlay
Liberty
Mansfield
Mentor
Perrysburg
Sandusky
Springfield
Toledo
Troy
Warren
Youngstown
Zanesville
Crestview Hills (KY)

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. PRIMARY AND SECONDARY DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

Primary Diagnosis

Z00.6 Encounter for examination for normal comparison and control in clinical research program

Secondary Diagnosis

G30.0 Alzheimer's disease w/early onset
G30.1 Alzheimer's disease w/late onset
G30.8 Other Alzheimer's disease
G30.9 Alzheimer's disease, unspecified
G31.84 Mild cognitive impairment, unknown etiology

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

***Recent baseline brain MRI required prior to initiating treatment**
***Referring provider is responsible for obtaining an MRI within approximately one week prior to the 3rd, 5th, 7th, and 14th infusions**

Administer 10 mg/kg IV over 1 hour Q2 weeks for 18 months
After 18 months
Q2 weeks Q4 weeks

-CMS Registry Letter Received and Attached
Yes No Registry Trial #: NCT06058234
Other ______________________________

Vital signs per HI Protocol
Anaphylaxis & Hydration Mgmt 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