

Select location:

Akron	Cleveland (Mayfield)	Dayton (Englewood)	Springfield
Anderson	Cleveland (North Olmsted)	Findlay	Toledo
Athens	Columbus (East Broad)	Liberty	Troy
Canton	Columbus (Hilliard)	Mansfield	Warren
Cincinnati (Blue Ash)	Columbus (Worthington)	Mentor	Youngstown
Cincinnati (West Side)	Dayton (Beavercreek)	Perrysburg	Zanesville
		Sandusky	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. DIAGNOSIS INFORMATION (ICD 10 Code Required)

Generalized Myasthenia Gravis (gMG) () Other _____

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

Dosing: SQ infusion once weekly x 6 weeks

Body Weight of Patient	Dose
Less than 50 kg	420 mg
50 kg to less than 100 kg	560 mg
100 kg and above	840 mg

Administer subsequent treatment cycles based on clinical evaluation; no sooner than 63 days from the start of the previous treatment cycle.

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)
 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
 Prednisone _____ mg PO

Other _____

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (<i>specify</i>): _____
CRP	Each Infusion	Other Frequency (<i>specify</i>): _____
CMP	Each Infusion	Other Frequency (<i>specify</i>): _____
ESR	Each Infusion	Other Frequency (<i>specify</i>): _____
Hepatic Panel	Each Infusion	Other Frequency (<i>specify</i>): _____
Renal Panel	Each Infusion	Other Frequency (<i>specify</i>): _____

Quantiferon TB Gold, annually, last completed (*date*): _____

Other (*specify*): _____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE