Horizon Infusions

Rheumatology/Dermatology Stelara Order Form

Select patient referral location: ☐ Akron ☐ Athens ☐ Blue Ash ☐ Cleveland ☐ Columbus ☐ Crestview Hills ☐ Dayton ☐ Mansfield ☐ Perrysburg ☐ Springfield ☐ Toledo ☐ West Cincinnati

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*)

☐ Psoriatic Arthritis (_____) ☐ Psoriasis (_____) ☐ ICD 10 (_____) ☐ Other: _____

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
☐ 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