

**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)

Emphysema () Alpha Antitrypsin Deficiency () Other:

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

ARALAST GLASSIA	PRE-MEDICATIONS N/A
Administer 60mg/kg IV once per week	Acetaminophen 500mg 650mg 1000mg
	Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
PROLASTIN-C	Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)
Administer 60mg/kg (+/- 10%) IV once per week	Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
	Prednisone mg PO
Vital signs per HI Protocol	Other
Anaphylaxis & Hydration Management per HI Protocol	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