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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)

***Labs: Hep B required prior to initial infusion**

Rheumatoid Arthritis (_____)	Pemphigus Vulgaris (PV) (_____)
Granulomatosis with Polyangitis (GPA) (_____)	Microscopic Polyangitis (MPA) (_____)
Other: _____	

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

RITUXAN	RUXIENCE	TRUXIMA	RIABNI
Initial	Maintenance		
Administer 1000mg at Day 1 and Day 15; Repeat every _____ weeks			
First infusion in series: 50mg/hr, increasing every 30 minutes by 50mg/hr to maximum of 400mg/hr			
Subsequent infusion in series: 100mg/hr, increasing every 30 minutes by 100mg/hr to maximum of 400mg/hr			
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 (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