



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)

Panlobular Emphysema ()	Alpha1 Antitrypsin Deficiency ()	Other:			
AAT Phenotype/Genotype	PiZZ	PiZ (null)	Pi (null, null)	PiSZ	Other:
Serum AAT Level mg/dL or µM					

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

PROLASTIN-C

Administer 60mg/kg (+/- 10%) IV once per week

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