Infliximab

Select location:

Akron
Anderson
Athens
Canton
Cincinnati (Blue Ash)
Cincinnati (West Side)
Cleveland (Mayfield)
Cleveland (North Olmsted)
Columbus (East Broad)
Columbus (Hilliard)
Columbus (Worthington)
Dayton (Beavercreek)
Dayton (Englewood)
Findlay
Liberty
Mansfield
Perrysburg
Springfield
Toledo
Warren
Crestview Hills (NKY)

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*) - Hep B and TB required prior to initial infusion

Rheumatoid Arthritis (_______)
Ankylosing Spondylitis (_______)
Plaque Psoriasis (_______)
Psoriatic Arthritis (_______)
Crohn's Disease (_______)
Ulcerative Colitis (_______)
Other: ____________

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

Use preferred Infliximab product per payer recommendations

Product name: ______________________________

To be completed by Horizon Infusions

______________________ ______________

Horizon Clinical Signature Dated

Loading Dose

Administer _____mg OR _____mg/kg at week 0, week 2, and week 6

Maintenance

Administer _____mg OR _____mg/kg IV every ____ weeks

May be rounded up to vial size infused over 2 hours, OR infuse at ____________________

Vital signs per HI protocol

Anaphylaxis and 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