Select location:

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

Myasthenia Gravis (______________) Other: ______________________

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

Administer 10mg/kg weekly x4 weeks, administered over 1 hour
OR
≥ 120kg: 1200mg weekly x4 weeks, administered over 1 hour

Select for additional treatment cycles
_________ (Indicate number of cycles)

- Subsequent cycles may require additional insurance authorization
- Treatment cycles will be given 50 days from the start of the previous treatment cycle

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