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*)

Active Stills Disease (_______________)
Gout Flares (_______________)
Periodic Fever Syndromes (_____________)
Other: _______________

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

For Stills Disease, including Adult Onset Stills Disease and Systemic Juvenile Idiopathic Arthritis:
4mg/kg (max of 300mg) weight ≥ 7.5kg SQ Q 4 weeks

For Cryopyrin-Associated Periodic Syndromes (CAPS):
150mg weight > 40kg SQ Q 8 weeks
2mg/kg weight ≥ 15kg and ≤40kg SQ Q 8 wks

For Gout flares:
150mg SQ. In patients who require re-treatment, there should be an interval of at least 12 weeks before a new dose can be administered

For Tumor Necrosis Factor Receptor Associated Periodic Syndrome, Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency, Familial Mediterranean Fever:
Weight ≤ 40kg
2mg/kg SQ Q 4 weeks
4 mg/kg SQ Q 4 weeks - consider if clinical response not adequate

Weight > 40kg
150mg SQ Q 4 weeks
300mg SQ Q 4 weeks - consider if clinical response not adequate

Vital signs per HI protocol
Anaphylaxis & hydration management per HI protocol

6. PRE AND POST MEDICATIONS

PRE-MEDICATIONS
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
Acetaminophen 500mg 650mg 1000mg
Prednisone __________ mg PO
Other ______________________________

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE DATE