



Select referral location:

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

**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)**

Generalized Pustular Psoriasis(\_\_\_\_\_) Other: \_\_\_\_\_ **\*TB required prior to initial infusion**

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

<b>SPEVIGO</b>	<b>PRE-MEDICATIONS</b>	N/A
Dosing: 900mg IV over 90 minutes	Acetaminophen	500mg 650mg 1000mg
Vital signs per HI Protocol	Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Anaphylaxis & Hydration Management per HI Protocol	Diphenhydramine (Benadryl)	25mg 50mg PO IV (requires driver)
	Methylprednisolone (Solu-Medrol)	40mg 80mg 125mg IV
	Prednisone _____ mg PO	
	Other _____	
	<b>POST-MEDICATIONS</b>	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