



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)

Multiple Sclerosis () Other () *Hep B, TB, and IG levels required prior to initial infusion

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

OCREVUS	Initial	Maintenance	PRE-MEDICATIONS	N/A
Initial Dose: Administer 300mg intravenous infusion, followed two weeks later by a second 300mg intravenous infusion			Acetaminophen	500mg 650mg 1000mg
Maintenance Dose: 600mg intravenous infusion every 6 months			Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Vital signs per HI Protocol			Diphenhydramine (Benadryl)	25mg 50mg PO IV (requires driver)
Anaphylaxis & Hydration Management per HI Protocol			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