



**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)**

Osteoporosis ( )      Other: \_\_\_\_\_

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

<b>EVENITY</b>	<b>PRE-MEDICATIONS</b>	N/A
Administer 210mg SubQ every 4 weeks X 12 months	Acetaminophen	500mg    650mg    1000mg
<b>OR</b>	Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Administer _____	Diphenhydramine (Benadryl)	25mg    50mg    PO    IV (requires driver)
Vital signs per HI Protocol	Methylprednisolone (Solu-Medrol)	40mg    80mg    125mg IV
Anaphylaxis & Hydration Management per HI Protocol	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 \_\_\_\_\_