



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)

Rheumatoid Arthritis (_____) Other: _____
 Juvenile Idiopathic Arthritis (_____)

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

ORENCIA	Initial	Maintenance	PRE-MEDICATIONS	N/A
Initial Dose: Administer at week 0, week 2 and week 4			Acetaminophen	500mg 650mg 1000mg
500mg (2 vials) 750mg (3 vials) 1000mg (4 vials)			Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Maintenance Dose: Administer every 4 weeks			Diphenhydramine (Benadryl)	25mg 50mg PO IV (requires driver)
500mg (2 vials) 750mg (3 vials) 1000mg (4 vials)			Methylprednisolone (Solu-Medrol)	40mg 80mg 125mg IV
Infuse over 30 minutes OR			Prednisone _____ mg PO	
Infuse at _____			Other _____	
Vital signs per HI Protocol			POST-MEDICATIONS	N/A
Anaphylaxis & Hydration Management per HI Protocol			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