Select referral location:

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

Myasthenia Gravis (_______________) Other: _______________________

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

Administer 10mg/kg weekly x4 weeks, administered over 1 hour
OR
$\geq$ 120kg: 1200mg weekly x4 weeks, administered over 1 hour

Select for additional treatment cycles
_________ (Indicate number of cycles)

- Subsequent cycles may require additional insurance authorization
- Treatment cycles will be given 50 days from the start of the previous treatment cycle

Vital signs per HI Protocol
Anaphylaxis & Hydration Management per HI protocol

PRE-MEDICATIONS N/A

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 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