



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)

Severe Active Lupus Nephritis ( ) Other \_\_\_\_\_  
 Severe Active Central Nervous System Lupus ( )

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

BENLYSTA	PRE-MEDICATIONS	N/A
Initial Dose: Administer 10mg/kg at IV week 0, 2, and 4	Acetaminophen	500mg 650mg 1000mg
Maintenance Dose: Administer 10mg/kg IV Q4 weeks	Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Administer 200mg SubQ once weekly	Diphenhydramine (Benadryl)	25mg 50mg PO IV (requires driver)
	Methylprednisolone (Solu-Medrol)	40mg 80mg 125mg IV
	Prednisone	_____ mg PO
	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