Horizon Infusions

Stelara ustekinumab

Select referral location:

- ☐ Akron
- ☐ Athens
- ☐ Canton
- ☐ Cincinnati (Blue Ash)
- ☐ Cincinnati (West)
- ☐ Cleveland
- ☐ Columbus (East Broad)
- ☐ Columbus (Hilliard)
- ☐ Columbus (Worthington)
- ☐ Dayton (Beavercreek)
- ☐ Dayton (Englewood)
- ☐ Findlay
- ☐ Liberty
- ☐ Mansfield
- ☐ 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*)

☐ Psoriatic Arthritis (_____) ☐ Psoriasis (_____) ☐ Other: _____

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

RHEUMATOLOGY/DERMATOLOGY STELARA

- ☐ ≤ 100kg: 45mg administered subcutaneously initially and 4 weeks later, followed by 45mg administered subcutaneously every 12 weeks
- ☐ > 100kg: 90mg administered subcutaneously initially and 4 weeks later, followed by 90mg administered subcutaneously every 12 weeks
- ☐ 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**