Horizon Infusions

Skyrizi (risankizumab-rzaa)

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	

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 (*and year of diagnosis*)

Crohn's Disease(_____)   Ulcerative Colitis (_____)   ICD 10 (_____)   Other: _____

TB required prior to initial infusion

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

Loading Dose - Crohn's Disease
Administer 600mg IV at week 0, week 4, and week 8

Loading Dose - Ulcerative Colitis
Administer 1200mg IV at week 0, week 4, and week 8

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**