



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)

Multiple Sclerosis () Other () *Hep B, TB, and IG levels required prior to initial infusion

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

OCREVUS	Initial	Maintenance	PRE-MEDICATIONS	N/A
Initial Dose: Administer 300mg intravenous infusion, followed two weeks later by a second 300mg intravenous infusion			Acetaminophen	500mg 650mg 1000mg
Maintenance Dose: 600mg intravenous infusion every 6 months			Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Vital signs per HI Protocol			Diphenhydramine (Benadryl)	25mg 50mg PO IV (requires driver)
Anaphylaxis & Hydration Management per HI Protocol			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