Horizon Infusions

Xolair (Omalizumab)

Select location:

Akron	Cleveland (Mayfield)	Dayton (Englewood)
Anderson	Cleveland (North Olmsted)	Findlay
Athens	Columbus (East Broad)	Liberty
Canton	Columbus (Hilliard)	Mansfield Toledo
Cincinnati (Blue Ash)	Columbus (Worthington)	Perrysburg Warren
Cincinnati (West Side)	Dayton (Beavercreek)	Springfield Crestview Hills (NKY)

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 Asthma (_____)

CIU (_____)   Allergic Asthma (_____)   Other: _____

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

XOLAIR

Administer _____ mg SubQ every _____ weeks

OR

Administer _____

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