



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:             |  | Allergies:                 |  |
| Social Security #: |  | Weight: _____ Lbs _____ Kg |  |
| Gender: M F        | 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 (_____)       | Allergic Asthma (_____) | CIU (_____) |
| Eosinophilic Asthma (_____) | Other: _____            |             |

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

|  |                                  |  |
|--|----------------------------------|--|
| <b>FASENRA</b>                                       | <b>PRE-MEDICATIONS</b>           | N/A  |
| Induction: 30mg Q4 weeks for 1 <sup>st</sup> 3 doses | Acetaminophen                    | 500mg 650mg 1000mg                             |
| Maintenance: Q8 weeks thereafter                     | 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 _____                      |  |
|  | <b>POST-MEDICATIONS</b>          | 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