



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 Persistent Asthma, Uncomplicated (_____)	IgE-Mediated Food allergy (_____)	Other _____
Chronic Spontaneous Urticaria (CSU) (_____)	Polyp of Nasal Cavity (_____)	

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

XOLAIR	PRE-MEDICATIONS N/A
Administer _____ mg SubQ every _____ weeks	Acetaminophen 500mg 650mg 1000mg
OR	Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
Administer _____	Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)
Vital signs per HI Protocol	Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
Anaphylaxis & Hydration Management per HI Protocol	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