



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: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> 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)

Rheumatoid Arthritis (_____) Systemic Juvenile Idiopathic Arthritis (_____) ***Hep B and TB required prior to initial infusion**
 Polyarticular Juvenile Idiopathic Arthritis (_____) Other _____

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

ACTEMRA	PRE-MEDICATIONS	N/A
Administer ____mg/kg IV every ____ week(s)	Acetaminophen	500mg 650mg 1000mg
Vital signs per HI Protocol	Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Anaphylaxis & Hydration Management per HI Protocol	Diphenhydramine (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