Horizon Infusions

Infliximab

Select location:

- ☐ Akron
- ☐ Anderson
- ☐ Athens
- ☐ Canton
- ☐ Cincinnati (Blue Ash)
- ☐ Cincinnati (West Side)
- ☐ Cleveland (Mayfield)
- ☐ Cleveland (North Olmsted)
- ☐ Columbus (East Broad)
- ☐ Columbus (Hilliard)
- ☐ Columbus (Worthington)
- ☐ Dayton (Beavercreek)
- ☐ Dayton (Englewood)
- ☐ Findlay
- ☐ Liberty
- ☐ Mansfield
- ☐ Perrysburg
- ☐ Springfield
- ☐ Toledo
- ☐ Warren
- ☐ 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*) - Hep B and TB required prior to initial infusion

☐ Rheumatoid Arthritis (_____) ☐ Ankylosing Spondylitis (_____) ☐ Plaque Psoriasis (_____)
☐ Psoriatic Arthritis (_____) ☐ Crohn's Disease (_____) ☐ Ulcerative Colitis (_____) ☐ Other: _____

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

☐ Use preferred Infliximab product per payer recommendations

☐ Product name: _____ *To be completed by Horizon Infusions*

_____ Horizon Clinical Signature

_____ Dated

Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg
☐ Other:_____
☐ Round up to nearest 100mg OR ☐ Give exact dose
(If not indicated, will round)

Frequency: ☐ Induction: week 0, 2, 6, and then every 8 wks
☐ Maintenance: every 8 weeks ☐ other: _____

Infusion Rate: Select one below. Patients who tolerate induction and the initial maintenance infusion without severe reaction will be eligible for 1 hour infusion
☐ Infuse over 2 hours (standard rate)
☐ Infuse over 1 hour (when patient eligible)

☐ Vitals and Anaphylaxis Mgmt per HI Protocol

PRE-MEDICATIONS ☐ N/A
☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
☐ 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*): _____
☐ Quantiferon TB Gold, annually, last completed *(date)*: _____
☐ Other (*specify*):_____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE | **DATE**