



Gastroenterology Stelara Referral Form

Select patient referral location: Blue Ash Worthington Crestview Hills Springfield West Cincinnati
Fax completed form to 888-977-0914. For new referrals, please include recent labs and last two office visit notes.

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

2. PHYSICIAN INFORMATION

Physician's name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

3. DIAGNOSIS INFORMATION (and year of diagnosis)

Crohn's Disease (_____) ICD 10 (_____) Other (specify): _____

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

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

STELARA <input type="checkbox"/> Initial <input type="checkbox"/> Maintenance	PRE-MEDICATIONS <input type="checkbox"/> N/A
<input type="checkbox"/> Initial Dose: Administer _____ mg IV over one hour OR	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
<input type="checkbox"/> infuse at _____	<input type="checkbox"/> Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
Thereafter, administer Maintenance Dose:	<input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> PO <input type="checkbox"/> IV (requires driver)
<input type="checkbox"/> SQ 90mg every 8 weeks OR	<input type="checkbox"/> Methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg <input type="checkbox"/> 80mg <input type="checkbox"/> 125mg IV
<input type="checkbox"/> _____	<input type="checkbox"/> Prednisone _____ mg PO
	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Vital signs per HI Protocol	POST-MEDICATIONS <input type="checkbox"/> N/A
<input type="checkbox"/> Anaphylaxis & Hydration Management per HI Protocol	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
	<input type="checkbox"/> Prednisone _____ mg PO
	<input type="checkbox"/> Other: _____

6. LABS

<input type="checkbox"/> CBC w/Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): _____		
<input type="checkbox"/> Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE