Horizon Infusions

Ilumya Order 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: ☐ M ☐ F	Weight: ☐ Lbs ☐ Kg
Patient Status: ☐ New to therapy ☐ Continuing therapy	☐ 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)*

☐ Plaque Psoriasis (_____) ☐ **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)*

ILUMYA

☐ Initial Dose: Administer 100mg SubQ at weeks 0 and 4

☐ Maintenance Dose: Administer 100mg SubQ every 12 weeks

☐ Vital signs per HI Protocol

☐ Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ Fexofenadine (Allegra) 180mg PO *(or other non-sedating anti-histamine)*

☐ 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 PO

☐ 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