IVIG REFERRAL FORM

Updated July 2019

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides

Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code

☐ **C90.0** Multiple Myeloma
☐ **C91.10** Lymphoid Leukemia
☐ **D80.0** Hereditary Hypogammaglobulinemia
☐ **D80.2** Selective deficiency of IgA
☐ **D80.5** Immunodeficiency with Increased IgM
☐ **D81.2** SCID with Low or Normal B-Cell Numbers
☐ **D81.9** Combined Immunodeficiency, Unspecified
☐ **D83.8** Other Common Var. Immunodeficiencies
☐ **E13.40** Other specified diabetes mellitus w/ diabetic neuropathy, unspecified
☐ **G25.82** Stiff Person Syndrome
☐ **G61.0** Guillain-Barre Syndrome (GBS)
☐ **G62.9** Other Peripheral Neuropathy
☐ **G70.0** Myasthenia Gravis (MG)
☐ **G70.80** Lambert-Eaton Syndrome, unspecified
☐ **L10.9** Pemphigus
☐ **M32.9** Systemic lupus erythematosus (SLE)
☐ **M33.90** Dermatopolymyositis & Organ Involvement Unspecified
☐ **Q81.9** Epidermolysis Bullosa
☐ **Z94.81** BMT
☐ **C90.1** Plasma Cell Leukemia
☐ **D69.6** Thrombocytopenia
☐ **D80.1** Nonfamilial Hypogammaglobulinemia
☐ **D80.3** Selective deficiency of IgG Subclasses
☐ **D81.1** SCID with Low T- and B- Cell Numbers
☐ **D81.89** Other combined Immunodeficiencies
☐ **D83.1** CVID w/ Predominant Immunoregulatory T-Cell Disorders
☐ **D83.9** Common Var. Immunodeficiency, Unspecified
☐ **D84.9** CVID
☐ **G35** Multiple Sclerosis (MS)
☐ **G61.81** Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ **G63** Polyneuropathy in diseases classified elsewhere
☐ **G70.01** Myasthenia Gravis with (Acute) Exacerbation
☐ **L12.0** Pemphigoid
☐ **M30.3** Kawasaki's syndrome
☐ **M33.20** Polymyositis, Organ Involvement Unspecified
☐ **M36.0** Dermatomyositis
☐ **Z41.8** Prophylactic Immunotherapy
☐ **Other:** _____

PRESCRIPTION

SUPPLIES FOR INFUSION (If Necessary)
☐ NaCl 0.9% / D5W for flush: flush Line/Port with (3 - 5 ml for PIV and 5-10 ml for Central Line/Port) per nursing agency protocol *(NaCl 0.9% / D5W will be used based on IVIG compatibility)*
☐ Heparin for flush (100 Units / ml) (if RN keeps PIVor if needed for Central Line), flush with 3-5 ml per nursing agency protocol
☐ Sterile water for reconstitution of powder to make the requested concentration (for Carimune NF)
☐ Other: _____

PRE-MEDICATIONS: *To be administered 30 min prior to IVIG Infusion: (QTY: per infusion)*: ☐ Acetaminophen 650 mg PO
☐ Diphenhydramine 25 mg-50 mg ☐ Other: _____

IVIG (IMMUNOGLOBIN) ORDER:_____ *(IVIG brand will be chosen if not specified)*

INTRAVENOUS IMMUNOGLOBULIN Dose ☐ 0.4 gm/kg ☐ 1gm/kg ☐ 2gm/kg ☐ ____ gm
Infuse: ☐ IV daily for ____ day(s); repeat every _____ week(s) for_____ cycles Refills: _____
☐ Other_____ Refills: _____

SUBCUTANEOUS IMMUNOGLOBULIN Infuse: ☐ ____ gm OR _____ ml using _____ sites _____ time(s) per week for _____
Hydration order: ☐_____ml NS IV to be infused prior/concurrently with IVIG Refills: _____

ACCESS	**NS HEPARIN**	**100 u/ml** *(If applicable, flush IV access device per Pharmacy protocol)*
Peripheral	1-3ml before/after use	10u/ml 1-2mls after last NS flush
Midline, central (non-port), PICC	NS 5-10 mls before/after use;	10mls after blood draw 10 u/ml 3-5mls after last NS flush; 5mls after blood draw
Implanted Port	5-10mls before/after use;	20mls after blood draw 100 u/ml 5mls after last NS flush; 5mls after blood draw
Tunneled	5-10mls before/after use;	20mls after blood draw 10 u/ml 3- mls after last NS flush. 5mls after blood draw
Groshong PICC, Midline	5-10mls before/after use;	10mls after blood draw NO Heparin needed

IN THE EVENT OF ANAPHYLAXIS:
- Stop Infusion and call MD & 911
- Diphenhydramine 25 - 50 mg IVP every 4 hours prn (Not to exceed 25 mg/min) QTY: 3 (50 mg)
- Epinephrine (1:1000) 0.4 mg SQ prn anaphylaxis, may repeat every 20 minutes x 2 QTY: 3 amp

Other _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.

My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.