Immunoglobulin referral form

Infusion Pharmacy Phone: 1-877-342-9352 Fax: 1-888-594-4844

✂ Please detach before submitting to a pharmacy – tear here.

IG specialist: Name: Phone:

Patient information ☐ see attached

Patient name: Gender: ○ M ○ F DOB: Last 4 of SSN:
Address: City: State: ZIP:
Phone: Cell:
Emergency contact: Phone: Relationship:

Insurance: ☐ Front and back of insurance cards to follow
Primary Insurance: Phone: Policy #: Group:
Secondary Insurance: Phone: Policy #: Group:

Primary diagnosis ICD-10 code (required): ☐ Med list attached

Medical assessment: Height: Weight: ○ lbs ○ kg
Current medications? ○ Yes ○ No If yes, list or attach:
Allergies:

Prescription and orders Medication, x1 year infused per the drug PI recommended rate and via rate controlled device per therapy

Immune Globulin: ☐ No preference ☐ Preferred product:
Directions: ☐ Infuse IV ☐ Infuse SC ☐ Per manufacturer guidelines or as written: ☐ May round to the nearest 5gm vial size
Initial: gm/kg divided over days; OR ☐ Other:
Ongoing: gm/kg divided over days, every weeks for cycles; OR ☐ Other:
Quantity/Refills: ☐ 1-month supply; refill x 12 months unless otherwise noted ☐ Other:

Pre-medications 30 minutes before start of IG:

☐ Acetaminophen PO ○ 325 mg ○ 650 mg mg ☐ DiphenhydrAMINE PO ○ 25mg ○ 50mg ○ mg
☐ Hydration, solution: Volume: ml/hr: ☐ Other:

Nursing and other orders:

☐ Administer IVIG or teach SCIG self-administration, via pump ☐ Ambulatory pump if required for infusion
☐ Initiate access device (insert peripheral IV, SC needles, access implanted port, or use existing PICC)
☐ Flush IV with 5ml 0.9% NaCl; Heparin 100 units/ml OR 10 unit/ml, 3-5ml PRN
☐ Obtain labs (list): Lab frequency: ☐ Once ☐ Monthly ☐ Other:
☐ **Anaphylaxis Kit** Order Infusion Reaction Management x1 year

Mild	• Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated. ☐ DiphenhydrAMINE PO ○ 25mg ○ 50mg ○ mg Dispense diphenhydrAMINE 25mg capsules x 4
Moderate	• Stop Infusion, resume at 50% rate when symptoms resolve ☐ DiphenhydrAMINE IV ○ 25mg ○ 50mg ○ mg Dispense diphenhydrAMINE 50mg vial x 1
Severe (Anawphylaxis) ***Call 911*** **Notify prescribing physician**	• Stop infusion and remove tubing from access device to prevent further administration • Initiate 0.9% NaCl 500ml/hr IV OR ml/hr • **Administer EPINEPHrine 1mg/ml by weight (Wt.) as an IM injection into the lateral thigh** Wt > 66lbs (30kg) 0.3mg/0.3ml; Wt 33 to 66 lbs (15 to 30kg) 0.15mg/0.15ml; Wt < 33lbs (15kg) 0.01mg/kg • Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist • Administer CPR if needed until EMS arrive ☐ Dispense EPINEPHrine x 2 ☐ 1mg vial ☐ Pen JR 0.15mg ☐ Pen 0.3mg ☐ Other:

Physician information

Name: Practice:
Address: City: State: ZIP:
Phone: Fax: NPI: Contact:

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Substitution permissible signature Dispense as written signature Date

Please fax this completed form with a copy of any medical history and labs relevant to the prescribed therapy.