# of Pages Faxed: _____
Fax Referral To: (440) 443-0700
Phone: (216) 381-3333

Autoimmune Referral Form

OIS Ohio Infusion Services

Date Required: _____ Ship To: ☐ Home ☐ Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
HomePhone: _____
Cell Phone: _____
Alternate Phone: _____
Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

☐ G04.81 Other Encephalitis and
☐ Encephalomyelitis M33.90 Dermatomyositis
☐ D69.3 Idiopathic Thrombocytopenia Purpura
☐ M30.3 Kawasaki Disease
☐ L12.8 Pemphigoid, Unspecified
☐ L10.9 Pemphigus, Unspecified
☐ M33.20 Polymyositis
☐ Other: _____

☐ Patient demographics, including insurance information.
☐ Labs – Antibody testing results, most recent BUN/SCr and IgA
☐ level H&P
☐ Medications/Therapies tried and failed
☐ Baseline assessment, including detailed patient symptoms
☐ Please attach original prescription orders

PATIENT EVALUATION

Has patient previously received IVIG? ☐ Yes ☐ No
Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
Line Access: ☐ Peripheral ☐ PICC ☐ Port
Delivery Method: ☐ Infusion Pump ☐ Other: _____
Therapy Start Date: _____ Therapy End Date: _____

PRESCRIPTION INFORMATION

Immune Globulin Prescription:

Loading Dose: IVIG _____ gm or _____ gm/kg once daily for _____ day(s) IVIG

Maintenance: _____ gm or _____ gm/kg once daily for _____ day(s)

☐ Repeat course every _____ week(s) x _____ course(s)
☐ Refill x _____ (length of time)

☐ OK to round to the nearest vial size+/- 4
☐ days to allow scheduling flexibility

Multiple doses will be administered on consecutive days unless ordered otherwise.
☐ non-consecutive days only

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol
☐ NaCl 0.9% 5ml
☐ NaCl 0.9% 10ml
☐ Heparin 10 units/ml
☐ Heparin 100 units/ml
☐ 250ml 0.9% NaCl for hydration
☐ Other: _____

Pre-Medications & Other Medications
☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol
☐ Acetaminophen _____ mg PO prior to infusion
☐ Diphenhydramine _____ mg PO

Prescriber Signature: _____ **Date:** _____