

# Autoimmune Referral Form



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 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: \_\_\_\_\_

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

**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  Heparin 10 units/ml  250ml 0.9% NaCl for hydration  
 NaCl 0.9% 10ml  Heparin 100 units/ml  Other: \_\_\_\_\_

**Pre-Medications & Other Medications**

Infusion supplies as per protocol  Acetaminophen \_\_\_\_\_ mg PO prior to infusion  
 Anaphylaxis Kit orders as per protocol  Diphenhydramine \_\_\_\_\_ mg PO

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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