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

Immune Globulin
Immunology Referral Form

OIS Ohio Infusion Services

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

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
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:

☐ For immune deficiency:
Detailed infection history, baseline IgG levels (including subclasses), immune response to vaccinations (including report)
☐ Other: _____

☐ Patient demographics, including insurance information.
☐ Labs – Antibody testing results, most recent BUN/SCr and IgA level
☐ H&P
☐ Please attach original prescription orders

DIAGNOSIS

Immunological:

☐ D81.9 Combined Immunodeficiency, Unspecified D83.9
☐ Common Variable Immunodeficiency (CVID) D80.0
☐ Hereditary Hypogammaglobulinemia
☐ D84.9 Immunodeficiency, Unspecified
☐ D80.5 Immunodeficiency with Hyper IgM
☐ D80.1 Nonfamilial Hypogammaglobulinemia D80.2
☐ Selective IgA Immunodeficiency
☐ D80.3 Selective IgG Immunodeficiency
☐ D80.4 Selective IgM Immunodeficiency
☐ D81.0 Severe Combined Immunodeficiency (SCID) D82.0
☐ Wiskott-Aldrich Syndrome
☐ 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: _____

PRESCRIPTION INFORMATION

Rx Intravenous Route:
IVIG _____ grams daily for _____ day(s)
Repeat course every _____ week(s) for a total of _____ course(s).

Rx Subcutaneous Route:
IG _____ grams each month given as _____ doses or IG _____ grams _____ times per month.
Administer SCIG using _____ sites at a time. Repeat _____ week(s). Refill x 1yr.

☐ Brand: _____ ☐ Pharmacy to select brand

☐ 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:** _____