

Immune Globulin Neurology Referral Form



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

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Alternate Phone: _____	DEA #: _____ NPI #: _____
Date of Birth: _____	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	PATIENT EVALUATION
<p>Neurological:</p> <input type="checkbox"/> G61.81 Chronic Inflammatory Demyelinating Polyneuropathy <input type="checkbox"/> (CIDP) M33.10 Dermatomyositis <input type="checkbox"/> G61.0 Guillian-Barré Syndrome <input type="checkbox"/> G70.80 Lambert-Eaton Syndrome <input type="checkbox"/> G62.89 Multifocal Motor Neuropathy (MMN) <input type="checkbox"/> G35 Multiple Sclerosis (Relapsing/Remitting) <input type="checkbox"/> G70.01 Myasthenia Gravis w/Acute Exacerbation <input type="checkbox"/> G62.9 Polyneuropathy, Unspecified <input type="checkbox"/> M33.22 Polymyositis <input type="checkbox"/> G25.82 Stiff-Person Syndrome <input type="checkbox"/> Other: _____	<p>Has patient previously received IVIG? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Patient Weight: _____ kg <input type="checkbox"/> lbs Height: _____ cm <input type="checkbox"/> in</p> <p>Allergies: _____</p> <p>Line Access: <input type="checkbox"/> Peripheral <input type="checkbox"/> PICC <input type="checkbox"/> Port</p> <p>Delivery Method: <input type="checkbox"/> Infusion Pump <input type="checkbox"/> Other: _____</p> <p>Therapy Start Date: _____ Therapy End Date: _____</p>
<input type="checkbox"/> Patient demographics, including insurance information. <input type="checkbox"/> Labs – Antibody testing results, most recent BUN/SCr and IgA level <input type="checkbox"/> H&P <input type="checkbox"/> Medications/Therapies tried and failed <input type="checkbox"/> Baseline assessment, including detailed patient symptoms <input type="checkbox"/> Please attach original prescription orders	<p>As Appropriate:</p> <input type="checkbox"/> Nerve Conduction Study results, including velocities <input type="checkbox"/> Biopsy results <input type="checkbox"/> Electromyography (EMG) results <input type="checkbox"/> CSF studies <input type="checkbox"/> Other: _____

PRESCRIPTION INFORMATION

<p>Immune Globulin Prescription:</p> <p>Loading Dose: IVIG _____ gm/kg given over _____ day(s) OR _____ gm daily for _____ day(s)</p> <p>Maintenance: IVIG _____ gm/kg given over _____ day(s) OR _____ gm daily for _____ day(s)</p> <input type="checkbox"/> Repeat course every _____ week(s) x _____ course(s) <input type="checkbox"/> Refill x _____ (length of time) <p>Subcutaneous Prescription:</p> <p>IG _____ gm monthly OR _____ gm every _____ weeks.</p> <p>Administer SCIG using _____ sites at a time. Repeat _____ week(s). Refill x 1yr.</p>	<input type="checkbox"/> OK to round to the nearest vial size +/- 4 <input type="checkbox"/> days to allow scheduling flexibility
<p>Multiple doses will be administered on consecutive days unless ordered otherwise.</p> <input type="checkbox"/> non-consecutive days only	

PREMEDICATION ORDERS/OTHER MEDICATIONS

<p>Flush Protocol</p> <input type="checkbox"/> NaCl 0.9% 5ml <input type="checkbox"/> NaCl 0.9% 10ml	<input type="checkbox"/> Heparin 10 units/ml <input type="checkbox"/> Heparin 100 units/ml	<input type="checkbox"/> 250ml 0.9% NaCl for hydration <input type="checkbox"/> Other: _____
<p>Pre-Medications & Other Medications</p> <input type="checkbox"/> Infusion supplies as per protocol <input type="checkbox"/> Anaphylaxis Kit orders as per protocol		
<input type="checkbox"/> Acetaminophen _____ mg PO prior to infusion <input type="checkbox"/> Diphenhydramine _____ mg PO		

Prescriber Signature: _____ **Date:** _____