

Immune Globulin Immunology Referral Form



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 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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