IMMUNE GLOBULIN INFUSION REFERRAL FORM

AristaCare

Phone (903) 295-3338 or (800) 280-3338 • Fax (903) 295-0004

Today's Date

❑ CURRENT PATIENT
❑ NEW PATIENT

Patient Name _____ SS# _____ DOB_____
Height _____ Weight _____ Address _____ Apt # _____
❑ Male ❑ Female City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____
Ship to Patient at ❑ Home ❑ Work OR Patient will pick up at ❑ Physician Office ❑ Pharmacy Date Needed _____
Medical History: ❑ Cardiac Disease ❑ Diabetes ❑ Renal Dysfunction ❑ IgA Deficient
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list)_____

Diagnosis:
❑ D80.0 Hereditary Hypogammaglobulinemia
❑ D81.5 Immune Deficiency with Increased IgM
❑ D83.9 Common Variable Immunodeficiency, unspecified
❑ D82.0 Wiskott Aldrich Syndrome
❑ D81.9 Combined Immunodeficiency, unspecified
❑ Other _____

Primary Insurance Company: _____ Policy#: _____ Group ID#:_____
Policyholder Name: _____ Rx BIN#: _____ Rx PCN#:_____
Policyholder DOB: _____ Relation to Patient: _____ Type: ❑HMO ❑PPO ❑PBM ❑Medicare ❑Medicaid

Secondary Insurance Company: _____ Policy#: _____ Group ID#:_____
Policyholder Name: _____ Rx BIN#: _____ Rx PCN#:_____
Policyholder DOB: _____ Relation to Patient: _____ Type: ❑HMO ❑PPO ❑PBM ❑Medicare ❑Medicaid

Prescriber's Name _____ Office Contact _____
Street Address _____ Suite#_____ City _____ State _____ Zip _____
Tel _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS AND HISTORY OF IG LABS

Is this the first dose? ❑ Yes ❑ No
If no, list product _____
Date of last infusion _____
Next dose due _____

ADMINISTER IVIG:
❑ _____ gm/kg or _____ grams _____ every _____ wk(s) for _____ cycle(s)
❑ Rate per manufacturer recommendation ❑ Other _____
❑ Other _____

ADMINISTER SQIg:
❑ IG _____ grams each month given as _____ doses ❑ IG _____ grams _____ times per month.
❑ Administer SQIg using _____ sites at a time. Repeat _____ week(s). OK to round dose to the nearest vial size. Refill x 1 year.
❑ Other _____

PRE-MEDICATIONS
❑ Diphenhydramine (Benadryl) 25-50 mg orally before infusion ❑ Other _____
❑ Acetaminophen (Tylenol) 325-650 mg orally before infusion

ADVERSE/ANAPHYLACTIC REACTIONS: PER INS STANDARDS CARE PROTOCOL
Adults or Children greater than 66 pounds or 30 kg:
- For mild reaction: give Diphenhydramine 50 mg orally, IM or IV and decrease the rate of infusion.
- For moderate reaction: stop infusion, give Diphenhydramine 50mg, orally, IM or IV and contact physician
- For Severe reaction w/breathing problem: stop infusion, call 911, give Epinephrine 0.3mg/0.3ml subcutaneously, Diphenhydramine 50 mg IV or IM. Begin NS 0.9% NaCI 500ml IV at a rate of 100-150ml/hr and contact physician.

Note: **Dosage adjustment necessary for children less than 30kg or 66 pounds:** Diphenhydramine 1.25mg/kg orally, IM or IV with a maximum of 50mg. If Epinephrine is needed 0.15mg/0.15ml 1:1000 subcutaneously

Nursing: Start PIV as required for administration and nurse to administer infusion in home.
Flushing: INS Standards Care Protocol (Heparin, 0.9% NaCI, D5W)
Lab Order(s):_____
Access: ❑ Peripheral ❑ PICC ❑ Port ❑ Other _____

By signing this form and utilizing our services, you are authorizing the pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS)_____ Date_____