



# IMMUNE GLOBULIN INFUSION REFERRAL FORM

REF: 847-306-3597

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 Date of last infusion \_\_\_\_\_  
 If no, list product \_\_\_\_\_ 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% NaCl 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. Access:  Peripheral  PICC  
 Flushing: INS Standards Care Protocol (Heparin, 0.9% NaCl, D5W)  Port  
 Lab Order(s): \_\_\_\_\_  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 \_\_\_\_\_

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