



IMMUNE GLOBULIN NEUROLOGY REFERRAL FORM

Phone (888) 383-4852 • Fax: (888) 383-8430

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: G61.0 Guillain-Barre Syndrome G70.80 Lambert-Eaton Syndrome, unspecified
 G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) M36.0 Dermatomyositis
 G61.9 Inflammatory Polyneuropathy, unspecified G25.82 Stiff-Person Syndrome
 G70.01 Myasthenia Gravis with (Acute) Exacerbation G35 Multiple Sclerosis (MS)
 M33.20 Polymyositis, organ involvement 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:

- 2 grams/kg over _____ days, as a loading dose, then _____ grams every _____ wk(s) for _____ cycle(s)
- _____ gm/kg or _____ grams _____ every _____ wk(s) for _____ cycle(s)
- Rate per manufacturer recommendation Other _____
- Other _____

PRE-MEDICATIONS

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

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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