Immune Globulin (IG) Referral Form

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SHIP TO:	❑ Patient's Home	❑ Provider's Office	❑ Other:

PATIENT INFORMATION:

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):	Sex: ❑ M ❑ F	
Patient Address: (include apt. #)			City:	State:	Zip:
Home Phone:	Work Phone:		Cell Phone:	Primary Language:	
Med List:	Allergies:		Height: ❑in ❑cm	Weight: ❑lb ❑kg	

PHARMACY INSURANCEINFORMATION:

Primary Insurance Name:	Insured's SSN:	Patient ID#:
Rx BIN#:	Rx PCN#:	Rx Group#:

****Please include a copy of the front and back of the patient's pharmacy insurance card with this form****

PRESCRIBING PHYSICIAN INFORMATION:

Physician Name:	Specialty:	Contact Name:
Physician Address:	Phone #:	Secure Fax #:
Physician DEA # :	Physician NPI #:	License #:

IN ORDER TO SERVICE YOUR PATIENT AND FACILITATE INSURANCE AUTHORIZATION, PLEASE ATTACH THE FOLLOWING DOCUMENTATION TO YOUR FAX:

❑ Patient demographics, including insurance information
❑ H&P
❑ Labs: Most recent BUN/SCr and IgA level
❑ If not the first dose:
  ❑ Product: ____
  ❑ Date of last infusion: ___________ Next dose due: ____________

❑ For immune deficiency: Detailed infection history, baseline IgG levels (including subclasses), immune response to vaccinations (including report)
❑ For ITP: Platelet count
❑ For post-BMT or BCT: ❑ Allogenic ❑ Autologous
❑ Other:
____

PRIMARY DIAGNOSIS:

❑ C91.1 Chronic Lymphocytic Leukemia (CLL)
❑ D80.4 Selective IgM Immunodeficiency
❑ D80.3 Selective IgG Immunodeficiency
❑ D80.0 Congenital Hypogammaglobulinemia
❑ D80.5 Hyper IgM
❑ D83.9 Common Variable Immnunodeficiency
❑ G70.0 Myasthenia Gravis without exacerbation

❑ D81.0 Severe Combined Immunodeficiency (SCID)
❑ D69.3 Idiopathic Thrombocytopenic Purpura (ITP)
❑ G35 Multiple Sclerosis
❑ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
❑ M30.3 Kawasaki Disease
❑ Other (ICD-10 Code and Description):
____

PRESCRIPTION INFORMATION:

****Please include an original prescription with this form or E-scribe a prescription to Kings Pharmacy****

Medication:
❑ Preferred product: _______________________________
❑ No preference

Dose:
❑ ______ gm once daily for _____ day(s) every _____ week(s)
❑ ______ total gm infused over ____ day(s) every ____ week(s)

Directions:
❑ Infuse IV over ______ hours
❑ Infuse IV per manufacturer's guidelines

Quantity/Refills:
❑ 1 month supply; refill x 12 months unless otherwise noted
❑ Other: ______________________________________

- OK to round to the nearest 5 gm vial size
- +/- 4 days to allow scheduling flexibility ❑ Decline

- Multiple doses will be administered on consecutive days unless ordered otherwise:
  ❑ Consecutive *or* non-consecutive days ❑ Non-consecutive days only

❑ Coordination of nursing services for home-infusion therapy

ANCILLARY MEDICATIONS/SUPPLIES:

❑ Acetaminophen 325 mg: 2 tabs PO 30 min prior to infusion
❑ Diphenhydramine 25 mg PO 30 min prior to infusion
❑ Epi-Pen 0.3 mg IM PRN for anaphylactic reaction
❑ Lidocaine/prilocaine 2.5% cream: Apply to IV site prior to access PRN

❑ NS: 250 mL pre- and post-infusion PRN for hydration and/or headache
❑ NS: 500 mL pre- and post-infusion PRN for hydration and/or headache
❑ Other: ____
____

PRESCRIBER SIGNATURE: **DATE:**

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