InfuCare Rx

Immune Globulin Immunology Referral Form

of Pages Faxed: ____________
Fax Referral To: 877-828-3941
Phone: 877-828-3940

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: ____________
Nursing Coordination:
☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No
☐ Home health nursing coordination not necessary. Reason:
☐ MD office to administer to patient
☐ Home health nursing already coordinated

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
☐ NaCl 0.9% 10ml
☐ Heparin 10 units/ml
☐ Heparin 100 units/ml
☐ 250ml 0.9% NaCl for hydration
☐ Other: ________________

Pre-Medications & Other Medications
☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol
☐ Acetaminophen ________ mg PO prior to infusion
☐ Diphenhydramine ________ mg PO

Prescriber Signature: ________________________ **Date:** ________________

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