InfuCare Rx

Immune Globulin Neurology 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:

DIAGNOSIS

Neurological:

- ☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ M33.10 Dermatomyositis
- ☐ G61.0 Guillian-Barré Syndrome
- ☐ G70.80 Lambert-Eaton Syndrome
- ☐ G62.89 Multifocal Motor Neuropathy (MMN)
- ☐ G35 Multiple Sclerosis (Relapsing/Remitting)
- ☐ G70.01 Myasthenia Gravis w/Acute Exacerbation
- ☐ G62.9 Polyneuropathy, Unspecified
- ☐ M33.22 Polymyositis
- ☐ G25.82 Stiff-Person 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

- ☐ Patient demographics, including insurance information.
- ☐ Labs – Antibody testing results, most recent BUN/SCr and IgA level
- ☐ H&P
- ☐ Medications/Therapies tried and failed
- ☐ Baseline assessment, including detailed patient symptoms
- ☐ Please attach original prescription orders

As Appropriate:

- ☐ Nerve Conduction Study results, including velocities
- ☐ Biopsy results
- ☐ Electromyography (EMG) results
- ☐ CSF studies
- ☐ Other: ______________

PRESCRIPTION INFORMATION

Immune Globulin Prescription:

Loading Dose: IVIG _____ gm/kg given over ____ day(s) OR _____ gm daily for _____ day(s)
Maintenance: IVIG _____ gm/kg given over ____ day(s) OR _____ gm daily for _____ day(s)
☐ Repeat course every ________ week(s) x ________ course(s)
☐ Refill x ________ (length of time)

Subcutaneous Prescription:

IG ________ gm monthly OR ________ gm every ________ weeks.
Administer SCIG using ________ sites at a time. Repeat ________ week(s). Refill x 1yr.

☐ 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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