

# Immune Globulin Referral Form



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## Complete Patient Demographic Information in Section Below OR Attach Face Sheet from Patient Chart

First Name:	Middle Initial:	Last Name:	
Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	SSN:	
Street Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	

## Complete Patient Insurance Information in Section Below OR Attach Copies of Patient Insurance Card

Insurance Carrier Name - Primary:	Name of Insured:	Relationship:	
ID#:	Group #:	Insurance Phone:	
Rx Carrier Name - Secondary:	Rx ID#:	Rx Group #:	Rx Phone #:

## Complete Drug Therapy Information in Sections Below OR Attach Completed Prescription

<input type="checkbox"/> IVIg Dose _____ grams/kg/day X _____ days or _____ grams/day X _____ days Directions for administration: Route of Administration: <input type="checkbox"/> IV <input type="checkbox"/> SC <input type="checkbox"/> IM # of refills: _____ Ig Product: _____ <input type="checkbox"/> Do Not Substitute Access Device for IV: <input type="checkbox"/> Peripheral catheter <input type="checkbox"/> Other: _____  <b>Epinephrine:</b> <input type="checkbox"/> Patient weight ≥30 kg; inject 0.3mg IM PRN for adverse reaction to IVIG <input type="checkbox"/> Patient weight 15-30kg; inject 0.15mg IM PRN for adverse reaction to IVIG  See back of form for additional orders	<input type="checkbox"/> ICD-10 _____ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) <input type="checkbox"/> ICD-10 _____ Congenital Hypogammaglobulinemia <input type="checkbox"/> ICD-10 _____ Immunodeficiency with increased IgM <input type="checkbox"/> ICD-10 _____ Wiskott-Aldrich Syndrome <input type="checkbox"/> ICD-10 _____ Combined Immunity Deficiency <input type="checkbox"/> ICD-10 _____ Myasthenia Gravis <b>without acute exac.</b> <input type="checkbox"/> ICD-10 _____ Myasthenia Gravis <b>with acute exac.</b> <input type="checkbox"/> ICD-10 _____ Multiple Sclerosis <b>relapsing/remitting only</b> <input type="checkbox"/> ICD-10 _____ Polyneuropathy Idiopathic, <b>Progressive</b> <input type="checkbox"/> ICD-10 _____ Guillian-Barre Syndrome <input type="checkbox"/> ICD-10 _____ Multifocal Motor Neuropathy <input type="checkbox"/> ICD-10 _____ Common Variable Immune Deficiency (CVID) IgG Level: _____ Date: _____ <input type="checkbox"/> ICD-10 _____ Hypogammaglobulinemia IgG Level: _____ Date: _____  <input type="checkbox"/> Other: _____ ICD-10 Code: _____
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Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ pounds

Current Therapies/Medications: \_\_\_\_\_

Infused at MDO  Infused at home: Set up of Skilled nursing visits required

## Complete Prescriber Information in Section Below NOT Included on Attached Prescription

MD First Name: \_\_\_\_\_

UPIN:	MD Last Name:	DEA #:
Office Address:	State License #:	NPI:
Office Phone:	City:	State: Zip Code:
Office Contact Name:	Office Fax:	Office E-mail:

### SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS

I authorize Deliverit Pharmacy Infusion & Specialty to initiate a Prior Authorization on my behalf.

Dr:  <i>NO Substitution Permitted</i>	DATE
Dr:  <i>Substitution Permitted</i>	DATE