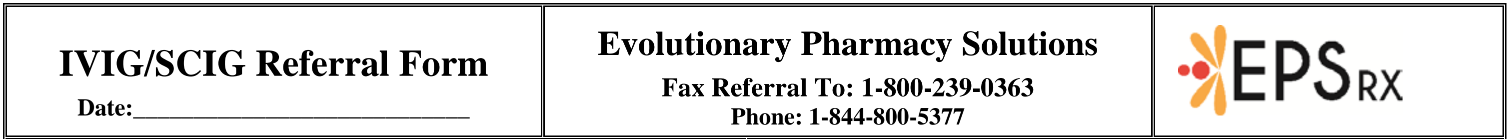

IVIG/SCIG Referral Form

Date:___________________________

Evolutionary Pharmacy Solutions

Fax Referral To: 1-800-239-0363

Phone: 1-844-800-5377

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ___________________________	Prescriber Name: ___________________________
Address: ___________________________	Address: ___________________________
City, State, Zip: ___________________________	City, State, Zip: ___________________________
Cell Phone: ___________________________	Phone: ____________________Alternative: ____________________
Home Phone: ____________________Language:____________________	Fax: ___________________________
Date of Birth: ____________________Gender: ☐ Male ☐ Female	DEA:____________________ NPI: ____________________
Guardian/Caregiver & Number: ___________________________	Office Contact: ___________________________
Email: ___________________________	Email: ___________________________

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card if available)

Insurance Name: ___________________________	Insurance Name: ___________________________
Cardholder: ____________________DOB____________________	Cardholder:____________________DOB ____________________
ID Number: ___________________________	ID Number:____________________PCN____________________
Group Number: ___________________________	Group Number: ____________________BIN____________________

CLINICAL INFORMATION

Diagnosis Code**:** ______________________________Vascular Access: ☐ Port ☐ Peripheral ☐ PICC ☐ Other: ____________

Patient Weight: ______________ Patient Height: ______________ Allergies: ______________________________

Has patient previously received IG: ☐ No ☐ Yes, Product Info:☐ SC ☐ IV ______________________________

Date of Last Infusion: ____________ Rate: ________________ Past Adverse Reaction:______________________________

PRESCRIPTION INFORMATION

☐ Carimune ☐ 3% ☐ 6% ☐ 9% ☐ 12% ☐ Cuvitru 20% ☐ Flebogamma 5% ☐ Flebogamma 10% ☐ Gammagard S/D ☐ 5% ☐ 10%

☐ Gammagard Liquid 10% ☐ Gammaked 10% ☐ Gammaplex 5% ☐ Gammaplex 10% ☐ Gamunex -C 10%

☐ Hizentra 20% ☐ HyQvia 10% ☐ Octagam 5% ☐ Octagam 10% ☐ Privigen 10% ☐ ____________________

Dose: ______________ mg/kg Total dose: ______________ grams Route: ☐ SC ☐ IV ☐ Number of sites:________

Directions: Infuse for ____________ days every ______________weeks Initial Infusion Date:______________________

Quantity to Dispense:______________ doses Refills: ____________________

Administration Rate: ☐ Per manufacture guidelines, as tolerated Rate: ____________________

Medication	Strength	#	Directions	Refills
☐ Acetaminophen	☐ 325mg ☐ 500 mg		Take ________ tablets by mouth prior to infusion.	
☐ Diphenhydramine	☐ 25mg PO ☐ 50 mg/ml IV		Take ________ tablets PO or ________mg IV prior to infusion.	
☐ EMLA Cream	2.5%/2.5%		Apply to affected area as needed as directed.	
☐ Epinephrine Autoinjector	☐ 0.15 mg ☐ 0.3 mg	2	Use as directed per anaphylaxis protocol	
☐ Sodium Chloride 0.9%	☐ 5 ml ☐ 10 ml		Flush IV with _____ ml before & after infusion & PRN line patency	
☐ Heparin	☐ 10 units/ml ☐ 100 units/ml		Flush IV with _____ ml after infusion & PRN line patency	
☐ Other				

Supplies: Pharmacy to provide supplies/equipment as needed for infusion
☐ Needles, syringes & any ancillary supplies ☐ Home medical equipment (pump, IV pole, etc)

Lab Orders: ________________________

Nursing Coordination:
☐ **YES:** Pharmacy to coordinate home health nursing visit as necessary (for education, SubQ training and/or administer medication to patient)
☐ **NO:** Nursing not necessary:☐ Patient and/or caregiver are proficient with infusion ☐ MD Office to train/administer ☐ Nursing already established

Treatment Setting: ☐ Patient's Home ☐ Physician's Office ☐ 1st dose at Physician's Office, then at patient home ☐ Infusion Suite___________

PRESCRIBER SIGNATURE: ______________________________ **DATE:**____________

Verbal Readback ☐ Yes ☐ No ***Stamp signature not allowed, physician signature required ***