Date:_____

IVIG/SCIG Referral Form

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Cell Phone: _____
Home Phone: _____Language:_____
Date of Birth: _____Gender: ☐ Male ☐ Female
Guardian/Caregiver & Number: _____
Email: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____Alternative: _____
Fax: _____
DEA:_____ NPI: _____
Office Contact: _____
Email: _____

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

Insurance Name: _____
Cardholder: _____DOB:_____
ID Number: _____
Group Number: _____

Insurance Name: _____
Cardholder:_____DOB:_____
ID Number:_____PCN:_____
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_____

Anaphylaxis Protocol: ☐ Follow Pharmacy's protocol (see attached) ☐ Follow Home Health protocol ☐ Follow Other: Please attached protocol

PRESCRIBER SIGNATURE: _____ **DATE:**_____

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