briova Rx® Infusion Services

General Immunoglobulin Referral Form

Phone: **1-877-342-9352**
Fax: 1-888-594-4844

✂ Please detach before submitting to a pharmacy – tear here.

PATIENT INFORMATION

IG specialist Name:______________________
Phone:______________________

Patient ☐ see attached Gender: O Male O Female

Patient name:______________________
DOB:____________ SSN:____________
Address:______________________
City:____________ State:________ Zip:________
Phone:____________ Cell:____________
Emergency contact:______________________
Phone:____________ Relationship:____________

Insurance ☐ Front and back of insurance card to follow

	Primary	**Secondary**
Insurance:		
Phone:		
Policy #:		
Group:		

Primary diagnosis
☐ Diagnosis code:____________ ☐ Med list attached
☐ Other: ______________________

Medical assessment
Height: ________ Weight:________ O lbs O kg

Current medications: O Yes O No
If yes, list or attach:

Allergies:

PRESCRIPTION ORDERS

Immune Globulin:
☐ No preference
☐ Preferred product:______________________

Initial:________ gm/kg divided over________ days
Ongoing:________ gm/kg divided over________ days
every________ weeks for________ cycles

Directions:
☐ Infuse IV ☐ Infuse SC
☑ Per manufacturer guidelines or as written below:
____
☑ May round to the nearest 5gm vial size

Quantity/Refills:
☐ 1-month supply; refill x 12 months unless otherwise noted
☐ Other:

Pre-medications 30 minutes before start of IG:
☐ Acetaminophen PO O 325 mg O 500 mg O 650 mg
☐ Diphenhydramine PO O 25 mg O 50 mg
☐ Hydration, solution: ____ Volume _____ mL
☐ Other: ______________________

Nursing and other orders:
☑ Administer IVIG or teach SCIG self-administration, via pump
☑ Ambulatory pump if required for infusion
☑ Initiate access device (insert peripheral IV, SC needles, access implanted port, or use existing PICC)
☑ Flush PIV with 5mL NS (for other orders, contact physician)
☐ Obtain labs (list):______________________
Lab frequency: ☐ Once ☐ Monthly ☐ Other:____________

☑ **Infusion reaction management and kit order**

Mild	Slow infusion rate by 50% until symptoms resolve Diphenhydramine PO O 25 mg O 50 mg ☐ other:______________		
Moderate	Stop infusion, resume at 50% when symptoms resolve Diphenhydramine IV O 25 mg O 50 mg ☐ other:______________		
Severe (Anaphylaxis) *Call 911*	Stop infusion; initiate 0.9% NaCl 500 mL IV Administer epinephrine 1 mg/mL by weight (Wt):		
	Wt > 66 lbs (30 kg) = 0.3 mg/.3mL	Wt 33 - 66 lbs (15 - 30 kg) = 0.15 mg/0.15mL	Wt < 33 lbs (<15 kg) = 0.01 mg/kg
	Repeat epinephrine in 5-15 min if symptoms continue. Administer CPR if needed until EMS arrives.		

PHYSICIAN INFORMATION

Name:______________________ Address:______________________
Practice:______________________ City:____________ State:________ Zip:____________
Phone:____________ Fax:____________ NPI:____________ Contact:____________

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Substitution permissible Signature:______________ Date:__________ *Dispense as written* Signature:______________

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