



General Immunoglobulin Referral Form

Infusion Pharmacy

Phone: 1-877-342-9352

Fax: 1-888-594-4844

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

PATIENT INFORMATION

IG specialist	Name:	Primary diagnosis	
	Phone:	<input type="checkbox"/> Diagnosis code:	<input type="checkbox"/> Med list attached
Patient	<input type="checkbox"/> see attached	Gender: <input type="radio"/> Male <input type="radio"/> Female	<input type="checkbox"/> Other:
Patient name:			
DOB:	SSN:		
Address:			
City:	State:	Zip:	
Phone:	Cell:	Height:	Weight: <input type="radio"/> lbs <input type="radio"/> kg
Emergency contact:		Current medications: <input type="radio"/> Yes <input type="radio"/> No	
Phone:	Relationship:	If yes, list or attach:	
Insurance	<input type="checkbox"/> Front and back of insurance card to follow		
	Primary	Secondary	
Insurance:			Allergies:
Phone:			
Policy #:			
Group:			

PRESCRIPTION ORDERS Medication infused per PI recommended rate and via rate controlled device per therapy

Immune Globulin:	<input type="checkbox"/> No preference <input type="checkbox"/> Preferred product:
Directions:	<input type="checkbox"/> Infuse IV <input type="checkbox"/> Infuse SC <input checked="" type="checkbox"/> Per manufacturer guidelines or as written: _____ <input checked="" type="checkbox"/> May round to the nearest 5gm vial size _____
Initial:	_____ gm/kg divided over _____ days; OR <input type="checkbox"/> Other: _____
Ongoing:	_____ gm/kg divided over _____ days, every _____ weeks for _____ cycles; OR <input type="checkbox"/> Other: _____
Quantity/Refills:	<input type="checkbox"/> 1-month supply; refill x 12 months unless otherwise noted <input type="checkbox"/> Other: _____

Pre-medications 30 minutes before start of IG:

<input type="checkbox"/> Acetaminophen PO <input type="radio"/> 325 mg <input type="radio"/> 650 mg <input type="radio"/> _____ mg	<input type="checkbox"/> DiphenhydrAMINE PO <input type="radio"/> 25 mg <input type="radio"/> 50 mg <input type="radio"/> _____ mg
<input type="checkbox"/> Hydration, solution: _____ Volume: _____ mL/hr: _____	<input type="checkbox"/> 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 IV with 5mL 0.9% NaCl; Heparin 100 units/mL OR 10 unit/mL, 3-5mL PRN
 Obtain labs (list): _____ Lab frequency: Once Monthly
 Other: _____

Anaphylaxis Kit Order Infusion Reaction Management 1 year

Mild	• Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated. <input checked="" type="checkbox"/> DiphenhydrAMINE PO 25mg 50mg _____ mg Dispense diphenhydrAMINE 25mg capsules x 4						
Moderate	• Stop infusion, resume at 50% rate when symptoms resolve <input checked="" type="checkbox"/> DiphenhydrAMINE IV1 25mg 50mg _____ mg Dispense diphenhydrAMINE 50mg vial x 1						
Severe (Anaphylaxis)	• Stop infusion and remove tubing from access device to prevent further administration • Initiate 0.9% NaCl 500mL/hr IV OR _____ mL/hr <input checked="" type="checkbox"/> Dispense 0.9% NaCl 500mL x 1 • Administer EPINEPHrine 1mg/mL by weight (Wt.) as an IM injection into the lateral thigh <table border="0"> <tr> <td>Wt > 66lbs (30kg)</td> <td>Wt 33 to 66 lbs (15 to 30kg)</td> <td>Wt < 33lbs (15kg)</td> </tr> <tr> <td>0.3mg/0.3mL</td> <td>0.15mg/0.15mL</td> <td>0.01mg/kg</td> </tr> </table>	Wt > 66lbs (30kg)	Wt 33 to 66 lbs (15 to 30kg)	Wt < 33lbs (15kg)	0.3mg/0.3mL	0.15mg/0.15mL	0.01mg/kg
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0.3mg/0.3mL	0.15mg/0.15mL	0.01mg/kg					
Call 911 Notify prescriber	• Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist • Administer CPR if needed until EMS arrives <input checked="" type="checkbox"/> Dispense EPINEPHrine x 2: 1mg vial Pen JR 0.15mg Pen 0.3mg Other: _____						

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: _____