Immunology Immunoglobulin Referral Form

OPTUM®

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: _____
Phone: _____

Patient ☐ see attached Gender: ○ Male ○ 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:
☐ Combined immunodeficiency
☐ Common hypogammaglobulinemia
☐ Common variable immunodeficiency
☐ Immune thrombocytopenic purpura
☐ Immunodeficiency with increased IgM
☐ Wiskott-Aldrich syndrome
☐ Other: _____

Medical assessment
Height: Weight: ○ lbs ○ kg
Current medications? ○ Yes ○ No
If yes, list or attach:
Allergies:

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

Immune Globulin: ☐No preference ☐Preferred product: _____

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

Initial: _____ ○ grams ○ gm/kg divided over ____ days; OR ☐Other: _____

Ongoing: _____ ○ grams ○ gm/kg over ____ days, every ____ weeks for ____ cycles; OR ☐Other: _____

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

Pre-medications 30 minutes before start of IG:

☐Acetaminophen PO ○ 325 mg ○ 650 mg ○ _____ mg
☐DiphenhydrAMINE PO ○ 25 mg ○ 50 mg ○ _____ mg
☐Hydration, solution: _____ Volume: _____ mL/hr: _____
☐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.
  ☑DiphenhydrAMINE PO ○ 25mg ○ 50mg ○ _____ mg Dispense diphenhydrAMINE 25mg capsules x 4

Moderate
- Stop Infusion, resume at 50% rate when symptoms resolve
  ☑DiphenhydrAMINE IV1 ○25mg ○50mg ○ _____ mg Dispense diphenhydrAMINE 50mg vial x 1

Severe (Anaphylaxis)
***Call 911* Notify prescriber**
- Stop infusion and remove tubing from access device to prevent further administration
- Initiate 0.9% NaCl 500mL/hr IV OR _____ mL/hr ☑ Dispense 0.9% NaCl 500mL x 1
- **Administer EPINEPHrine 1mg/mL by weight (Wt.) as an IM injection into the lateral thigh**

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

- Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist
- Administer CPR if needed until EMS arrives

☑ 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: _____