Neurology 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: 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

- ☐ Acute Infective Polyneuritis (Guillain–Barre Syndrome)
- ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ Critical Illness Polyneuropathy (Acute Motor Neuropathy)
- ☐ Multifocal Motor Neuropathy (MMN)
- ☐ Myasthenia Gravis with (Acute) Exacerbation
- ☐ Myasthenia Gravis without (Acute) Exacerbation
- ☐ Peripheral Neuropathy (Unspecified)
- ☐ Polymyositis
- ☐ Other: _____

Medical assessment

Height: Weight: O lbs O kg
Current medications: O Yes O 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: _____ gm/kg divided over _____ days; OR ☐ Other: _____
Ongoing: _____ gm/kg divided 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 O 325 mg O 650 mg O ____ mg	☐ DiphenhydrAMINE PO O 25 mg O 50 mg O ____ 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 O 25mg O 50mg O ____ mg Dispense diphenhydrAMINE 25mg capsules x 4

Moderate
- Stop Infusion, resume at 50% rate when symptoms resolve
  ☑ DiphenhydrAMINE IV O 25mg O 50mg O ____ 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: O 1mg vial O Pen JR 0.15mg O 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: _____