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: 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 Insurance: Phone: Policy #: Group:

Secondary Insurance: Phone: Policy #: Group:

Primary diagnosis: Diagnosis code: Med list attached

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: 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 325 mg 650 mg mg ☑ DiphenhydrAMINE PO 25mg 50mg 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 x1 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 IV 25mg 50mg mg Dispense diphenhydrAMINE 50mg vial x 1
Severe (Anaphylaxis) ***Call 911*** **Notify prescribing physician**	• Stop infusion and remove tubing from access device to prevent further administration • Initiate 0.9% NaCl 500mL/hr IV OR mL/hr • **Administer EPINEPHrine 1mg/mL by weight (Wt.) as an IM injection into the lateral thigh** Wt > 66lbs (30kg) 0.3mg/0.3mL — Wt 33 to 66 lbs (15 to 30kg) 0.15mg/0.15mL — Wt < 33lbs (15kg) 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: Practice:

Address: 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:

This form is not a valid prescription in Arizona.

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