Neurology immunoglobulin referral form

Infusion pharmacy
Phone: 1-877-342-9352
Fax: 1-888-594-4884

✂ 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:

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