Neurology immunoglobulin referral form

Phone: 1-877-342-9352
Fax: 1-888-594-4844

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) ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) ☐ Critical Illness Polyneuropathy (Acute Motor Neuropathy) ☐ Polymyositis ☐ Peripheral Neuropathy (Unspecified)	☐ Multifocal Motor Neuropathy (MMN) ☐ Myasthenia Gravis with (Acute) Exacerbation ☐ Myasthenia Gravis without (Acute) Exacerbation ☐ 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 5mg 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) 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:		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: