Immunoglobulin referral form

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

✂ Please detach before submitting to a pharmacy – tear here.

IG specialist: Name: _____ Phone: _____

Patient information ☐ see attached ☐ PEDIATRIC (younger than 13 years or less than 45kg in weight).

Patient name: _____ Gender: ○ M ○ F DOB: _____ Last 4 of SSN: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Cell: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Insurance: ☐ Front and back of insurance cards attached.

Primary Insurance: _____ Phone: _____ Policy #: _____ Group: _____

Secondary Insurance: _____ Phone: _____ Policy #: _____ Group: _____

Medical assessment

Primary diagnosis ICD-10 code (required): _____

Height in inches: _____ Weight **in kg only**: _____ Date weight (in kg) obtained: _____

Current medications? ○ Yes ○ No If yes, list here or attach a list: _____

Allergies: _____

Prescription and orders Medication, x1 year infused per the drug PI recommended rate and via rate controlled device per therapy

Immune Globulin: ☐ No preference ☐ Preferred product: _____ Dose will be rounded to the nearest vial size available.

Directions: ☐ Infuse IV ☐ Infuse SC ☐ Titrate per manufacturer guidelines or as written: _____

Initial loading: ____ gm/kg divided over ____ days every ____ weeks; OR ____ gm/day x ____ days every ____ weeks.

Maintenance: ____ gm/kg divided over ____ days every ____ weeks; OR ____ gm/day x ____ days every ____ weeks.

Other: _____

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

☑ Pharmacy to dispense flushes, needles, syringes and HME/DME in quantity sufficient to complete therapy as prescribed.

Premedication: Dispense PRN x 1 year (select below):

	Drug	Patient Type	Dose	Dispense detail	Directions
☐	DiphenhydrAMINE	Adult & Pediatric >30kg	50mg	Dispense 25mg capsules or tablets #100	Administer PO 30 minutes prior to IG. May repeat once if symptoms occur.
		Pediatric 15-30kg	25mg	Dispense 25mg/10mL oral solution 120mL	
		Pediatric <15kg	12.5mg	Dispense 12.5mg/5mL oral solution 120mL	
☐	Acetaminophen	Adult & Pediatric >30kg	325mg	Dispense 325mg tablets or 325mg/10.15mL unit dose oral solution #100 doses	Administer PO 30 minutes prior to IG. May repeat once if symptoms occur.
		Pediatric 15-30kg	160mg	Dispense 160mg tablets #30 or 160mg/5mL oral solution 120mL	
		Pediatric <15kg	80mg	Dispense 80mg/2.5mL oral solution 120mL	
☐	Hydration – Sodium Chloride 0.9%, (specify volume).	Adult & Pediatric	Volume _____ mL	Dispense bag(s) for infusion #QS	Infuse IV prior to IG, at a rate up to 900mL/hr.
☐	Lidocaine-Prilocaine Cream 2.5%	SCIG & Pediatric	n/a	Dispense 30Gm	Apply pea size amount topically to needle site(s) PRN.
☐	Other, specify _____				

Lab Draw Orders x1 year (specify below):

CMP ☐ once ☐ monthly ☐ other _____ **Serum creatinine/BUN** ☐ once ☐ monthly ☐ other _____

Other lab (specify): _____ Frequency ☐ once ☐ monthly ☐ other _____

Lab work to be obtained via IV access using aseptic technique. If RN is not able to draw labs from a central catheter, the labs may be drawn peripherally. RN to flush IV access after each blood draw with Sodium Chloride 0.9% 20 mL and use Heparin 10 units/mL 5mL (if port use Heparin 100 units/ml, 5ml) as final lock for patency.

Please fax both pages of this completed form with a copy of any medical history and labs relevant to the prescribed therapy.

This form is not a valid prescription in New York.

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Patient name: _____ DOB: _____

Nursing orders:

RN to complete assessment and administer IVIG via ambulatory pump or teach SCIG self-administration via syringe pump.

RN to insert peripheral IV or access central venous catheter.

RN to flush IV post infusion with 5mL 0.9% Sodium Chloride and lock line with heparin 10units/mL, 3mL; if port, lock with heparin 100units/mL, 5mL.

☑ **Anaphylaxis/infusion reaction management orders:** Dispense PRN x 1 year

Therapy Type	Drug	Patient Type	Dose	Dispense detail	Directions*
IVIG	DiphenhydrAMINE (for mild to severe symptoms)	Adult & Pediatric >30kg	50mg	Dispense 25mg capsules or tablets #4	For mild symptoms, RN to slow infusion rate by 50% until symptoms resolve. Administer diphenhydrAMINE PO x1. May repeat once if symptoms persist. For moderate to severe symptoms, RN to stop infusion. Administer diphenhydrAMINE slow IV push at rate not to exceed 25mg/minute. May repeat x1 if symptoms persist. For moderate symptoms, resume at 50% previous rate IF symptoms resolve.
				Dispense 50mg vial for injection #1	
		Pediatric 15-30kg	25mg	Dispense 25mg/10mL oral solution 120mL	
				Dispense 50mg vial for injection #1	
		Pediatric <15kg	12.5mg	Dispense 12.5mg/5mL oral solution 120mL	
				Dispense 50mg vial for injection #1	
IVIG	EPINEPHrine (for severe symptoms)	Adult & Pediatric >30kg	0.3mg/0.3mL	Dispense 1mg vial for injection #2	For severe symptoms (anaphylaxis), stop infusion. Disconnect tubing from access device to prevent further administration. Activate 911. Administer EPINEPHrine as an IM injection into the lateral thigh. Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist. Initiate Sodium Chloride 0.9% IV. Administer CPR if needed until EMS arrives. Contact prescriber to communicate patient status.
		Pediatric 15-30kg	0.15mg/0.15mL	Dispense 1mg vial for injection #2	
		Pediatric <15kg	0.01mg/kg	Dispense 1mg vial for injection #2	
SCIG	EPINEPHrine (for severe symptoms)	Adult & Pediatric >30kg	0.3mg/0.3mL	Dispense Autoinjector Pen 0.3mg #2	
		Pediatric 15-30kg	0.15mg/0.15mL	Dispense Autoinjector Pen JR 0.15mg #2	
		Pediatric 7.5-15kg	0.1mg/0.1mL	Dispense Autoinjector Pen 0.1mg (PED) #2	
IVIG	Sodium chloride 0.9% (for severe symptoms)	Adult & Pediatric	500mL	Dispense 500mL bag #1	For severe symptoms administer as IV gravity bolus (1000mL/hour).
IVIG	Other, specify _____				

*Mild symptoms include flushing, dizziness, headache, apprehension, sweating, palpitations, nausea, pruritus, and/or throat itching.
Moderate symptoms include chest tightness, shortness of breath, >20 mmHg change in systolic blood pressure from baseline, and/or increase in temperature (>2°F).
Severe symptoms include >40 mmHg change in systolic blood pressure from baseline, increase in temperature with rigors, shortness of breath with wheezing, and/or stridor.

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 Dispense as written signature Date

Please fax both pages of this completed form with a copy of any medical history and labs relevant to the prescribed therapy.

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