

IMMUNE GLOBULIN (IVIG) REFERRAL FORM



PATIENT: _____ SEX: MALE FEMALE WEIGHT: _____ LBS KGS HEIGHT: _____ IN CM
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ HOME CELL WORK _____ HOME CELL WORK DOB: _____
**MAY WE LEAVE MESSAGES ON THE PHONE? YES NO MAY WE TEXT YOU? YES NO SSN: _____
EMERGENCY CONTACT: _____ PHONE: _____ ICD-10: _____
DIAGNOSIS: _____

INSURANCE INFORMATION: FAX FRONT AND BACK OF ALL INSURANCE CARDS

PRIMARY INSURANCE: _____ ID: _____ GROUP: _____ INSURED PARTY: _____
SECONDARY INSURANCE: _____ ID: _____ GROUP: _____ INSURED PARTY: _____

CLINICAL INFORMATION: CLINICAL NOTES, LABS, TEST RESULTS, MEDICATION HISTORY, ALLERGIES

ACCESS DEVICE: PERIPHERAL IMPLANTED PORT PICC OTHER: _____
PREVIOUS IVIG/SCIG: YES NO IF YES, WHAT WERE THE PREVIOUS PRODUCTS: _____ DATE: _____
ALLERGIES: NKDA OTHER: _____

PRESCRIPTION: Administration by manufacturer guidelines and per state law, prescriptions will be dispensed as generic unless otherwise noted.

IVIG (PHARMACIST TO SELECT APPROPRIATE PRODUCT AND WHAT IS ON FORMULARY) OR BRAND: _____
DOSE: _____ G/KG or _____ GRAMS (TOTAL) ADMINISTERED OVER _____ DAYS
FREQUENCY: REPEAT EVERY _____ WEEKS FOR 1 YEAR or _____ CYCLES
**MAY ADJUST INFUSION SCHEDULE WITHIN +/- 7 DAYS IF NURSING NEED ARISES
**DO YOU WANT THE DOSE ADJUSTED FOR PATIENTS ABOVE 100KG YES NO OTHER: _____

PRE-MEDICATION/PROTOCOLS ADULTS AND PEDIATRICS:

DIPHENHYDRAMINE _____ MG 30 MINUTES BEFORE INFUSION. MAY REPEAT PRN UP TO EVERY _____ HOURS
 PO capsule PO Liquid 12.5mg/5mL Chewable IV Push
 ACETAMINOPHEN _____ MG PO 30 MINUTES BEFORE INFUSION. MAY REPEAT PRN UP TO EVERY _____ HOURS
 PO tablet PO liquid 160mg/5mL Chewable tablet
 HYDRATION: INFUSE _____ mL of _____ SOLUTION PRIOR AFTER INFUSION
 SOLUMEDROL® _____ MG IV Push or INFUSE IN 0.9% SODIUM CHLORIDE 50-250ML OVER 30 MINUTES
 OTHER: _____

FLUSHING PROTOCOL:

SODIUM CHLORIDE 0.9% 5-10mL PRE AND POST MEDICATIONS HEPARIN _____ Units/mL, _____ mL as needed

ANAPHYLAXIS ORDERS AND MEDICATIONS:

- STOP THE INFUSION, then CALL 911, PRESCRIBING PHYSICIAN AND PHARMACY (844-650-5802)
- ADMINISTER MEDICATIONS BELOW AS PER PROTOCOL: DIPHENHYDRAMINE 50MG/mL (1 vial)
- ADMINISTER 50MG/mL (weight > 30kg) by slow IV push or IM
 ADMINISTER 25MG/0.5mL (weight 15 - 30kg) by slow IV push or IM
 ADMINISTER 12.5MG/0.25 mL (weight 7.5 - 15kg) by slow IV push or IM
- EPINEPHRINE (VIAL OR AUTOINJECTOR): ADMINISTER IM FOR SEVERE ANAPHYLACTIC REACTION, MAY REPEAT IN 5-15 MINUTES IM x 1.
 0.3MG (weight > 30kg) 0.15MG for PEDIATRICS (weight 15-30kg) 0.1 MG for PEDIATRICS (weight 7.5-15kg)
- SODIUM CHLORIDE 0.9% 500mL IV use as directed

NURSING/LABS/SUPPLIES:

NURSING: Nursing visits with each infusion to establish venous access, administer and maintain medication, assess and monitor patient, provide education and complete lab draws.
LABS: Please select labs to be drawn prior to an infusion by the nurse. CBC CMP IgG/IgA/ IgM Sed Rate IgG, Subclasses
 Other: _____ Frequency of labs: Every _____ month(s).
 Supplies: Dispense medication, pump, and supplies necessary for infusion.

PRESCRIBER OF RECORD

PRESCRIBER: _____ NPI: _____ TAX ID: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
CONTACT: _____ PHONE: _____ FAX: _____
PRESCRIBER'S SIGNATURE: _____ DATE: _____

I authorize IV Solutions Rx and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions Rx.
CONFIDENTIALITY NOTICE: The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by replying by email at info@ivsolutionsrx.com and then destroying all copies of the original message.