SUBCUTANEOUS IMMUNE GLOBULIN (SCIg) REFERRAL FORM

PATIENT:_____ **SEX:** ◯ **MALE** ◯ **FEMALE** **WEIGHT:**_____◯ **LB** ◯ **KG** **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

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.

◯ **SCIG (PHARMACIST TO SELECT APPROPRIATE PRODUCT AND WHAT IS ON FORMULARY) OR** ◯**BRAND:**_____

DOSE: _____**GRAMS SC EVERY** _____ **WEEK** **or** _____**G/KG PER WEEK. MAY BE DIVIDED OVER 2 DAYS IF NEEDED.**

DISPENSE: 4 WEEK SUPPLY FOR ◯ **1 YEAR** **or** ◯ _____ **CYCLES**

PRE-MEDICATIONS/PROTOCOLS ADULT AND PEDIATRICS:

◯ **DIPHENHYDRAMINE**_____**MG 30 MINUTES BEFORE INFUSION.** ◯ **MAY REPEAT PRN UP TO EVERY** _____ **HOURS**
◯ **PO capsule** ◯ **PO Liquid 12.5mg/5mL** ◯ **Chewable**
◯ **ACETAMINOPHEN**_____**MG PO 30 MINUTES BEFORE INFUSION.** ◯ **MAY REPEAT PRN UP TO EVERY**_____**HOURS**
◯ **PO tablet** ◯ **PO liquid 160mg/5mL** ◯ **Chewable tablet**
◯ **OTHER:**_____
◯ **LIDOCAINE 2.5% and PRILOCAINE 2.5% CREAM (EMLA) 30 GRAMS TOPICAL, Apply small amount insertion site 30-60 MINUTES prior to needle insertion**

ANAPHYLAXIS ORDERS AND MEDICATIONS:

1. **STOP THE INFUSION**
2. **CALL 911, then call the PRESCRIBING PHYSICIAN and the PHARMACY (844-650-5802)**
3. **EPINEPHRINE (AUTOINJECTOR 2 PACK): 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)** ◯ **0.1MG for PEDIATRICS (weight 7.5-15kg)**

NURSING / SUPPLIES / EQUIPMENT

NURSING: Nursing visits to train patient/care provider and subcutaneous immunoglobulin administration, assess, monitor patient, provide education. 1-4 skilled nursing visits for the purposes of subcutaneous SCIg administration independent of the nurse. PRN thereafter to assess and refresh skills.
SUPPLIES: Dispense medication and supplies necessary for infusion. **PUMP:** Syringe Driver/Pump(s) ◯ **YES** ◯ **NO**

PRESCRIBER OF RECORD

PRESCRIBER:_____ **NPI:**_____ **TAX ID:**_____

ADDRESS:_____ **STE.**_____ **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.

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