Immunoglobulin (IVIG/SCig)
REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 **PHONE:** +1(844) 650-5802

IV Solutions RX

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE
Address: _____ **City/State/Zip:** _____
Primary Phone: _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____
Emergency Contact: _____ **Relationship to Patient:** _____ **Phone:** _____

2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

Primary Insurance: _____ **Policy No:** _____ **Group:** _____
Primary RX Insurance:_____ **ID No:**_____ **RX GRP:**_____ **RX BIN:**_____ **RX PCN:**_____

3 DIAGNOSIS AND CLINICAL INFORMATION

First time receiving Immunoglobulin Therapy? ☐ Yes ☐ No **If No, previous product used:** _____ **Last Dose Given:** _____

Patient Clinical Information:
Diagnosis (ICD-10): _____ **Description:** _____
Drug Allergies:_____ ☐ NKDA **Ht:** _____in/cm **Wt:** _____lbs/Kg

4 PRESCRIPTION INFORMATION

ACCESS: ☐ IV ☐ PORT ☐ SC **DO YOU WANT IG DOSE ADJUSTED FOR WEIGHT > 100KG:** ☐ YES ☐ NO

RX INFORMATION: Our pharmacist will identify clinically appropriate IgG brand *(Unless product is specifically specified at the time of referral)* and infusion rate per FDA guidelines. Clinically appropriate substitutions may be allowed based on availability or payor requirements. Round IVIg or SCig dose(s) to the nearest vial size. Official orders will be outlined with "May Infuse" +/- 3 days if scheduling needs arises, with insurance payor approval".

Product: ☐ Pharmacist to select appropriate product per insurance formulary, or
Brand: ☐ Cutaquig 16.5% ☐ GammaGARD Liquid 10% ☐ GammaGARD S/D ☐ GamuNEX-C 10% ☐ Hizentra 20% *PFS* ☐ HyQvia 10% ☐ Octagam 10% ☐ Octagam 5% ☐ Panzyga 10% ☐ PRIVIgen 10% ☐ Xembify 20% ☐ Other:_____

LOADING DOSE: _____ grams TOTAL IV DOSE or _____ mg/kg TOTAL dose over _____ admin days.

MAINTENANCE DOSE:_____ grams TOTAL IV DOSE or _____ mg/kg TOTAL dose over_____ admin days. Repeat every _____ days.

PRE/POST ORDERS:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☐ SoluMedrol® **(IV)**	Give _____ mg prior to infusion via ☐ IV push ☐ diluted in _____ mL of NS over 30 min.	Quantity: **Q.S**	Refills: **PRN**
☐ Diphenhydramine: ☐ PO ☐ IV ☐ Loratadine **(PO)**	Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**
☐ Acetaminophen **(PO)**	Administer _____ mg PO 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**
☐ Hydration: ☐ 0.9% NaCL ☐ LR	Infuse _____ mL of _____ solution ☐ before ☐ after infusion.	Quantity: **Q.S**	Refills: **PRN**
☐ Emla® cream ***(30 grams)***	Apply topically 30 to 60 minutes prior to access.	Quantity: **Q.S**	Refills: **PRN**

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☒ EPINEPHRINE **(vial or autoinjector)**	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes ☐ ***0.3 mg (Wt > 30 kg)*** ☐ ***0.15 mg (Wt 15-30 kg)*** ☐ ***0.1 mg (Wt 7.5-15 kg)***	Quantity: **(x1) Vial** or **(x2) Pen(s)**	Refills: **PRN**
☒ DIPHENHYDRAMINE **(50mg/mL)**	Administer via IM or slow IV push for severe anaphylactic reaction. ☐ ***50 mg (Wt > 30 kg)*** ☐ ***25 mg (Wt 15-30 kg)*** ☐ ***12.5mg (Wt 7.5-15kg)***	Quantity: **(x1) Vial(s)**	Refills: **PRN**
☒ SODIUM CHLORIDE 0.9% **(IV)**	Infuse 500 mL IV as directed for severe anaphylactic reaction.	Quantity: **500 mL**	Refills: **PRN**

NURSING/ LABS/ INFUSION SUPPLIES:

☒ **NURSING:** Nursing visits with each infusion to establish venous/port access, administer medication, assess and monitor patient, provide education, and complete lab draw
☒ **INFUSION SUPPLIES:** Infusion supplies and infusion pump PRN for the administration and disposal of medication.
FLUSHING PROTOCOL: ☒ Sodium chloride 0.9%, Up to 10 mL before/after medication, and/or PRN to maintain patency.
☐ Heparin: ☐ 10 Units/mL ☐ 100 Units/mL, _____ as final flush and/or PRN to maintain patency
☒ **LABS:** *[Dx code: Z79.899]*; Labs to be drawn by RN prior to infusion every _____ ☐ Week ☐ Month(s), as follows:
☐ **CMP** ☐ **CBC w/ diff** ☐ **ESR** ☐ **CK** ☐ **IgG Total** ☐ **IgG Subclasses 1-4** ☐ **Other:** _____

5 PRESCRIBER INFORMATION

Prescriber Name: _____ **Title:** ☐ MD ☐ DO ☐ ND ☐ PA ☐ APRN **NPI:**_____
Address:_____ **City/ State/ Zip:** _____
Phone:_____ **Fax:** _____ **Contact Person:**_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record.
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 refills 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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Physicians signature **Date**

THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE *#welcome to our family*