aleracare
advanced specialty pharmacy

Immune Globulin
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Diagnosis Information

- ◯ D80.1 Hypogammaglobulinemia
- ◯ D80.0 Congenital Hypogammaglobulinemia
- ◯ D80.5 Immunodeficiency with Increased IgM
- ◯ D83.9 Common Variable Immunodeficiency
- ◯ D82.0 Wiskott-Aldrich Syndrome
- ◯ D81.9 Combined Immunodeficiency
- ◯ D81.9 Combined Immunodeficiency
- ◯ G25.82 Stiff Person Syndrome
- ◯ G35 Multiple Sclerosis
- ◯ G62.89 Multifocal Motor Neuropathy
- ◯ G61.0 Guillain-Barré Syndrome
- ◯ G61.8 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ◯ G70.0 Myasthenia Gravis
- ◯ M33.90 Dermatomyositis
- ◯ M33.20 Polymyositis
- ◯ Other: _____ ICD-10 Code: _____
- ◯ Secondary Diagnosis: _____

Prescription Information

IVIG: Dose by Physician: _____ Dose by Pharmacist _____

Initial Loading Dose: IVIG: _____ G/Kg (ABW) IV Daily for _____ days

Maintenance Dose: IVIG: _____ G/Kg (ABW) IV once every _____ weeks/month

Duration: for 1 year until further order or: _____

Administration per pharmacy protocol or: _____

Preferred Brand: _____

Pre-Medication: *(15 to 30 minutes before infusion)*

1. Home Health Nurse to instruct patient to drink enough fluid (2-4 cups/day) prior to IVIG infusion. Nursing to assess patient's hydration status and comorbidities. Check with prescribing physician if patient is volume restricted.
2. Take 2 tablets 325mg of Acetaminophenby mouth 30 minutes prior to each infusino as MD directed.
3. Take 1-2 capsules 25mg of Diphenhydramine by mouth 30 minutes prior to each infusion or Diphenhydramine25-50mg slow IV push over 2-5 minutes.
4. IV Steriods: Dexamethasone: _____ SoluMedrol: _____ Solu-Cortef _____ Instruction: _____
5. IV Hydration: NS: _____ Other: _____ml: _____over: _____hours

Anaphylaxis Kit included: ◯ Yes ◯ No

Other Medication: PRN for infusion reaction per pharmacy protocol

Ibuprophen 400mg PO every 8 hours PRN

Famotidine 20mg IV _____

D5W or NS250ml IV _____

Hydrocortisone 100mg IV _____

Dexamethasone 10mg IV _____

Others: _____

LAB: Serum creatinine, BUN & urine output. Other labs prior to infusion and each monthly cycle.

By MD _____ or By Home Nurse _____

Catheter flushes per Nursing SASH Protocol: Heparin 3-5ml (100/units/ml) Saline 5-10ml or D5W 5-10ml.
Supplies for method of Administration and Type of Line used per Pharmacy Protocol.

Home Health Nurse To Monitor: Vital Signs and temperature pre-infusion, then every 15 minutes until maximum delivery rate is reached, then every hour x2, every 2 hours until completed and 15-30 minutes after completion of the infusion.

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature **Date**