aleracare
advanced specialty pharmacy

# Immune Globulin

## Referral Form

## Patient Information

Patient Name: DOB:

Address:

City: State: Zip:

Phone: Alternate Phone: SSN:

Height: Weight: Allergies:

Emergency Contant: Phone:

Is the patient pregnant, planning a pregnancy or nursing: Yes No

## Prescriber Information

Prescriber's Name:

NPI#:

DEA#: License#:

Address:

Phone: Fax:

Contact Person:

Does the patient need interpreter services: Yes No

## 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

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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: ______________________

Initial Loading Dose: IVIG: ______________________

Maintenance Dose: IVIG: ______________________

Dose by Pharmacist ______________________

G/Kg (ABW) IV Daily for ______________________ days

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

D5W or NS250ml IV ______________

Dexamethasone 10mg IV ______________

Famotidine 20mg IV ______________________

Hydrocortisone 100mg 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**