Immunoglobulin
Referral Form

aleracare advanced specialty pharmacy

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

Documentation (Required)

Insurance Card (ID & Group #)   Current Medications   History/Progress Notes

Labs Needed Prior to Initiation

CBC with diff   CMP   IG levels

Diagnosis

ICD-10 Codes: D80.0 Hereditary Hypogammaglobulinemia   D80.1 Non-familial Hypogammaglobulinemia   D81.9 Combined Immunodeficiency

D83.9 Common Variable Immunodeficiency   G35 Multiple Sclerosis   G61.8 Chronic Inflammatory Demyelinating Polyneuropathy

G70.0 Myasthenia Gravi   M33.90 Dermatopolymyositis   Other: _____

Medication	Dose and Directions for Use	Qty	Refills
GAMMAGARD® **GAMUNEX-C**® **HIZENTRA**® **PANZYGA**® **PRIVIGEN**® **XEMBIFY**® **Other:** _____	Initial dose: Infuse ____ gm IV or subq (circle one) for ____ day(s) every ____ weeks Maintenance dose: Infuse ____ gm IV or subq (**circle one**) for ____ day(s) every ____ weeks		

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