## Immunoglobulin Referral Form

Fax completed form to: 833-908-1122





PATIENT INFORMATION							
Patient Name:	Date of Birth:			Referral Date:			
Address:				City/State/Zip:			
Home Phone:		Cell Phone:			Work Phone:		
Secondary Contact:		Height:	Weight:		Male Female		
Patient Diagnosis & ICD-10:							
Allergies:							
PROVIDER INFORMATION							
Physician Name:		Lic.#:		DEA #:			
Practice Name:				NPI#:			
Address:				City/State/Zip:			
Office Contact:		Phone:			Fax:		
Supervisory Physician (if applicable):							
PLEASE ATTACH							
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results  Current medication list & list of prior medications tried and failed (with dates)  Letter of medical necessity if drug dosing or indication is outside of FDA guidelines							
Recent BUN & Creatinine results  Diagnostic testing (one or all) to match diagnosis:  Electromyography (EMG)  Nerve Biopsy  If			IG Serum Levels: IgG, IgA, Subclass Levels: Ig1, Ig2, Recent BUN & Creatinine Immunization challenge	ditional information required for immunology diagnosis only IG Serum Levels: IgG, IgA, and IgM Subclass Levels: Ig1, Ig2, Ig3, Ig4 Recent BUN & Creatinine results Immunization challenge test results and titers values Supporting documentation of chronic infection history, hospitalizations & previous treatment			
NURSING & LAB ORDERS							
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.							
Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mLOR 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line							
Lab Orders: Lab Date & Frequency:							
PRESCRIPTION ORDERS							
Anaphylaxis Kit: (Check all that apply)	ylaxis Kit: Epinephrine 0.3mg IM as needed Solu-cortef 250mg-500mg IV infusion as needed Solu-Medrol 60mg - 125mg IV infusion as needed						
Pre-Medications: Acetaminophenmg POminutes prior to infusion Solu-Medrolmg IVminutes prior to infusion  (Check all that apply) Heparin 5,000 units SubQ pre and post IG infusion Diphenhydraminemg POOR IV infusionminutes prior to infusion Other  Pre-Hydration NS Hydration 250ml-500 ml IV infusion over 30 minutes as needed							
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary							
PRODUCT		PRESCRI	PTION INFORMA	ATION		REFILLS	
Is this a first dose? Yes No If No, when was last dose given?When is patient due for next dose?							
IMMUNOGLOBULINS	Administration Route: IV infusionOR SC infusion  Dosing/Frequency:mg/kg divided overdays everyweeks mg/kg for one time dosemg everyweeks RPh Recommended Brand						
OTHER							
By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.							
Prescriber's Signature <u>Dispense as Written</u>	Print Name	Date	Prescriber's Signa Substitution Pern		Print Name	Date	







No MD signature required on this form for infusion therapy. The pharmacist or NP will be sending a fax with prescription order details that must be signed by the physician before this drug can be dispensed.