Immunoglobulin Referral Form

Fax Completed Form To: **Phone:**

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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

Additional information required for neurology diagnosis only
☐ Recent BUN & Creatinine results
☐ Diagnostic testing (one or all) to match diagnosis:
- ☐ Electromyography (EMG)
- ☐ Nerve Biopsy
- ☐ Muscle Biopsy
- ☐ Nerve Conduction Study

Additional 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/mL ***---OR---*** ☐ 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)
☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed
☐ Diphenhydramine _____ mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other

Pre-Medications: (Check all that apply)
☐ Acetaminophen _____mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____mg IV ____minutes prior to infusion
☐ Diphenhydramine _____ mg ☐ PO ***---OR---*** ☐ IV infusion _____minutes 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	PRESCRIPTION INFORMATION	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 infusion ***---OR---*** ☐ SC infusion Dosing/Frequency: _____mg/kg divided over _____days every _____weeks _____mg/kg for one time dose _____mg every _____weeks ☐ 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 **Print Name** **Date**
Dispense as Written

Prescriber's Signature **Print Name** **Date**
Substitution Permitted

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.