## Immunoglobulin Referral Form







## **Fax Completed Form To:**

## **Phone:**

PATIENT INFORMATION						
Patient Name:		Date of Birth:			Referral Date:	
Address:				City/State/Zi	p:	
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 □ 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/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:						
Pre-Medications:       ☐ Acetaminophenmg POminutes prior to infusion ☐ Solu-Medrolmg IVminutes prior to infusion         (Check all that apply)       ☐ 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		PRESCR	RIPTION INFORMA	TION		REFILLS
Is this a first dose?						
☐ IMMUNOGLOBULINS	mg/k	nOR SC infusio g divided overdays g for one time dose veryweeks		□ RPh Re	commended 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 Dispense as Written	Print Name	Date	Prescriber's Si Substitution I	-	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.