# **Immunoglobulin** Referral Form

**Fax Completed Form To: 877-418-4495  Phone: 877-418-4114**

amerita specialty infusion services

mosaic infusion solutions an amerita company

## 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<br>Dosing/Frequency: _____mg/kg divided over _____days every _____weeks<br>_____mg/kg for one time dose<br>_____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.*