

Immunoglobulin Order Form

Fax Completed Form To:

Phone:

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)			
☐ Current medication list & list of prior medications tried and failed (with dates)			
☐ 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		Additional information required for immunology diagnosis only	
☐ Recent BUN & Creatinine results		☐ IG Serum Levels: IgG, IgA, and IgM	
☐ Diagnostic testing (one or all) to match diagnosis:		☐ Subclass Levels: Ig1, Ig2, Ig3, Ig4	
☐ Electromyography (EMG)		☐ Recent BUN & Creatinine results	
☐ Nerve Biopsy		☐ Immunization challenge test results and titers values	
☐ Muscle Biopsy		☐ Supporting documentation of chronic infection history, hospitalizations & previous treatment	
☐ Nerve Conduction Study			
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: ☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed			
(Check all that apply) ☐ Diphenhydramine _____mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other			
Pre-Medications: ☐ Acetaminophen _____mg PO _____minutes prior to infusion ☐ Solu-Medrol _____mg IV _____minutes prior to infusion			
(Check all that apply) ☐ 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			_____

Prescriber's Signature
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

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.

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AME_Immunoglobulin Referral Form 7.31