PREMIER INFUSION CARE

Hepatitis B Immune Globulin REFERRAL FORM

Referral Line (866) 365-2525 | Referral Fax (866) 383-2525

*In order to service your patient and facilitate insurance authorization please complete the prescription section, then fax back with information below. Premier Infusion Care will confirm acceptance of service.

REFERRAL FACILITY NAME _____/_____

REFERRAL CONTACT NAME _____ ☐HOSPITAL ☐MD ☐RN AGENCY ☐INSURANCE ☐CASE MGR

CONTACT PHONE/PG _____ **CONTACT FAX** _____

Patient Information:

LAST NAME _____ FIRST NAME _____ DOB _____/_____/_____

HOME PHONE _____ WORK PHONE_____ CELL PHONE _____

DIAGNOSIS _____ ICD-9 _____

☐ Patients demographics, including insurance Information. (We will obtain authorization unless insurance dictates otherwise.)
☐ History & Physical and /or Progress Notes (s) confirming diagnosis
☐ Pertinent Labs (Preferred within last 30 days)
☐ Other: _____

Immune Globulin Prescription (Specify Brand):

☐**Nabi-HB or** ☐**Other (Specify)** _____

CHECK ONE:

☐ 5ml (in 2 divided doses) Intramuscularly once a month x _____ months.
☐ Other: _____

Lab Orders:

☐ Hepatitis B Surface antibody (quantitative) prior to each injection
☐ CBC, CMP, Mg, Phos q month
☐ Tacrolimus level drawn at 8 AM, prior to 9AM Meds
☐ Cyclosporine level drawn at 8 AM, prior to 9AM meds

Physicians Name _____

Office Contact (Required) _____

Address _____

City_____ Zip_____

Phone _____ Cell / PG _____ Fax _____

License _____ DEA _____ NPI _____

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Physicians Signature:

_____

Date: _____