PREMIER INFUSION CARE

Immune Globulin Prescription (Ig) REFERRAL FORM

Ig Territory Manager:

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 ______________________________

CONTACT PHONE/PG ______________________________ CONTACT FAX ______________________________

Patient Information:

PATIENT LAST NAME ____________________ PATIENT FIRST NAME ____________________ DOB ____/____/______

HOME PHONE ____________________ WORK PHONE ____________________ CELL PHONE ____________________

☐ Patients demographics, including insurance Information (We will obtain authorization unless insurance dictates otherwise.)

☐ History & Physical and /or Progress Notes (s) confirming diagnosis

☐ Other: ______________________________

☐ Labs:
- ☐ BUN/Creatinine (Preferred within last 90 days)
- ☐ Provide Serum IgG levels
- ☐ IgA and IgM (if available)
- ☐ Specific Antibody Titers
- ☐ PRA level

Immune Globulin Prescription: (Specify Brand & Concentration)______________________________ or Pharmacist to Determine ☐

PLEASE CHECK ONE:

☐ IV

☐ SubQ

☐ Ig ________gm* once daily x ________day(s) Repeat course every ______ ☐ Week(s) ** ______ ☐ Month(s) **

☐ Ig________gm*/ Kg once daily x ________day(s) For ______ courses OR refill x ______ (length of time)

☐ Ig ________gm*/ Kg / course over ________day(s) ☐ Okay to round to the nearest vial size.

Maximum total dose per course ________gm

** (+/-) 4 days to allow scheduling flexibility ☐ Decline

Multiple doses in a course may be adminstered on (Check One)

☐ Consecutive or Non-Consecutive Days ☐ Consecutive days ☐ Non-Consecutive days only ☐ Non-Dialysis days only

DIAGNOSIS:

Deficiency of humoral immunity 279.1 Deficiency of cell-mediated immunity

☐ 279.10 Immunodeficiency with predominant T-cell defect, unspecified

☐ 279.11 DiGeorge syndrome with thymic hypoplasia

☐ 279.12 Wiskott-Aldrich syndrome

☐ 279.13 Nezelof syndrome Cellular immunodeficiency with abnormal immunoglobulin deficiency

☐ 279.2 Combined immunity deficiency Agammaglobulinemia

☐ Other: ______________________________

☐ 279.00 Hypogammaglobulinemia, unspecified

☐ 279.01 IgA immunodeficiency

☐ 279.02 IgM immunodeficiency

☐ 279.03 Other selective Ig deficiencies

☐ 279.04 Congenital hypogammaglobulinemia / Agammaglobulinemia: Bruton's type; X-linked

☐ 279.05 Immunodeficiency with increased IgM

☐ 279.06 Common variable immunodeficiency: acquired; congenital; primary

☐ 279.09 Transient hypogammaglobulinemia of infancy

Premier Infusion Care's Recommended Orders:

- Acetaminophen 325 mg: 2 tabs (650 mg) PO pre-Ig prn; may be repeated every 3 hrs prn (max 12 tabs/day). ☐ Decline
- Antihistamine: Diphenhydramine (25 mg) PO pre-Ig prn; may be repeated every 3 hrs prn (max 4 tabs/day). ☐ Decline
  May give Loratadine (10 Mg) PO pre-Ig prn if excessive drowsiness from diphenhydramine. ☐ Decline
- If applicable, Flush intravenous access device per Premiers Protocol.
- If no current renal function lab results, draw BMP with first dose.
- Anaphylaxis kit orders (epinephrine auto-injector, diphenhydramine oral / injectable) per Premier's Protocol.
- When appropriate, first dose may be administered in the home /alternate care settings.
- When appropriate, skilled nurse to administer Ig and Medications(s).
- When appropriate, infusion pump to administer Ig.
- Supplies as appropriate to administer therapy.
- Refill medications x 1 year.

Other Orders: ______________________________

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.

Physicians Signature ______________________________

Date ______________________________

CONFIDENTIALITY NOTICE: If faxed materials include Protected Health Information (PHI), these records are CONFIDENTIAL. Premier Infusion Care shall receive authorization from the patient prior to releasing or utilizing PHI for reason other than treatment, payment or healthcare operations. If you are not the intended recipient, you are advised that any disseminations, distribution or copying of this communication is prohibited. Destroy if received in error.