Immunoglobulin Referral Form

Santa Rosa Pharmacy
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Phone: (850) 622 - 3313
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Referral Date: _____

Patient Information

Patient Name: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female ☐ Other **Height (in):** _____ **Weight (lbs):** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Emergency Contact/ PHI:** _____ **Phone:** _____

Allergies: _____ ☐ NKDA

Diagnosis

Neuromuscular	ICD-10
☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81
☐ Dermatopolymyositis	M33.90
☐ Gullian-Barre Syndrome (GBS)	G61.0
☐ Multifocal Motor Neuropathy	G61.82
☐ Myasthenia Gravis (MG)	G70.0
☐ Myasthenia Gravis With (Acute) Exacerbation	G70.01
☐ Polymyositis	M33.20
☐ Relapsing Remitting Multiple Sclerosis	G35
☐ Stiff Person Syndrome	G25.82
☐ Other: _____	

Immune Deficiency	ICD-10
☐ CVID With Predominant Immunoregulatory T-Cell Disorders	D83.1
☐ Combined Immunodeficiency, Unspecified	D81.9
☐ Common Variable Immunodeficiency, Unspecified	D83.9
☐ Hereditary Hypogammaglobulinemia	D80.0
☐ Immunodeficiency With Increased IgM	D80.5
☐ Nonfamilial Hypogammaglobulinemia	D80.1
☐ Other Combined Immunodeficiencies	D81.89
☐ Other Common Variable Immunodeficiency	D83.9
☐ Pemphigoid	L12.0
☐ Pemphigus	L10.9

Immune Deficiency	ICD-10
☐ SCID With Low or Normal B-Cell Numbers	D81.2
☐ SCID With Low T and B-Cell Numbers	D81.1
☐ Selective Deficiency of IgG Subclasses	D80.3
☐ Specific Antibody Deficiency	D80.6
☐ Systemic Lupus Erythematous	M32.9
Other	**ICD-10**
☐ Autoimmune Encephalopathy	G04.81
☐ Idiopathic Thrombocytopenic Purpura	D69.3
☐ Inflammatory Neuropathies	G61.89

Prescription

Immunoglobulin Orders

Is this a first dose? ☐ Yes ☐ No

If No, when was the last dose given? _____

When is the patient due for their next dose? _____

Administration Method: ☐ IVIG ☐ SCIG ☐ IMIG

Product (Brand): ☐ **Pharmacist to Determine Brand**

Specific Brand: _____

Dose: _____ Grams / kg (Range 0.2-2 Grams / kg) = _____ Grams

Infuse intravenously over _____ hours, as tolerated by patient

☐ **One time Dose** ***Refills:*** _____

Frequency: ☐ Divide dose over _____ days

☐ Repeat dose **weekly** x _____ weeks total.

☐ Repeat dose **monthly** x _____ months total.

☐ Other: _____

☐ Patient is at risk of developing renal dysfunction. If so, the rate of infusion must be reduced to an alternate rate.

Pre-Medication Orders (15 - 30 Minutes Prior to Infusion)

☐ **Acetaminophen** ☐ 1000 mg PO ☐ 500 mg PO

☐ **Diphenhydramine** ☐ 25 mg IV ☐ 50 mg IV

☐ **Hydration prior to Infusion:**

☐ **Other:** _____

Anaphylaxis Orders

☐ **Epinephrine 0.3 mg IM as needed**

☐ **Diphenhydramine** ☐ 25 mg ☐ 50 mg **IV as needed**

☐ **Solu-Cortef** ☐ 250 mg ☐ 500 mg **IV as needed**

☐ **Other:** _____

Flush Orders

☐ NaCl 0.9% - 5-10mL flush pre and post infusion and as needed

☐ Heparin 10 u/mL 3-5mL flush after post-infusion NS flush to maintain line

☐ Heparin 100 u/mL 3-5mL flush after post-infusion NS flush to maintain line

☐ D5W 50 mL for flush for Gamunex, Gammagard

Nursing Orders

* If no central IV access, RN to insert peripheral IV, rotate site every 72-120 hrs or as needed.
* Monitor vital signs (temp, HR, RR, BP) prior to infusion, every 15 min x 1 hr, every hr, and at completion of infusion
* Obtain weight before each dose.
* If infusion reaction occurs, decrease rate by 30mL/hr every 15 min & monitor vital signs until symptoms subside. If reaction persists or worsens, stop infusion & notify physician.

Lab Orders

☐ **Nursing agency to draw labs.**

Lab Orders: _____

Lab Date & Frequency: _____

Prescriber Information

Prescriber Name: _____ **NPI:** _____ **DEA:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

_____ _____

Prescriber' Signature **Print Name** **Date**

_____ _____

Prescriber' Signature **Print Name** **Date**

Dispense As Written

Substiution Permitted

Required Documentation - Please Fax to (850) 622 - 3255

☐ 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 documentation - Neurology Diagnoses

☐ Recent BUN and Creatinine Results

☐ Other Diagnostic Testing to Match Diagnosis (Mark all that apply):

☐ Electromyography ☐ Muscle Biopsy

☐ Nerve Biopsy ☐ Nerve Conduction Study

Additional Documentation - Immunology Diagnoses

☐ IG Serum Levels: IgG, IgA, IgM ☐ Recent BUN and Creatinine Results

☐ Subclass Levels: Ig1, Ig2, Ig3, Ig4 ☐ Immunization challenge test results and titers values

☐ Supporting documentation of chronic infection history, hospitalizations & previous treatment