Immune Globulin Referral

V.03.01.17.A

Phone: 877-385-0535 Fax: 877-326-2856

Patient Demographics

Name: ____ ☐M ☐F
DOB: __________________ SS#: ____________________________
Phone: ______________________ 2nd Phone: _______________________
Address: ____
City: _______________________ State: __________ Zip: ___________
Primary language, if other than English: __________________________

****Please fax a copy (front and back) of the patient's medical and prescription insurance cards.****

Provider Information

Prescriber: ____
____
Phone: __________________________ Fax: _______________________
Address: ____
____
NPI: _______________________ Office contact: ___________________
Deliver to: ☐Patient ☐Prescriber's Office (☐All fills ☐First fill only)

Diagnosis

Diagnosis (ICD-10 Code)
☐Hereditary hypogammaglobinemia (D80.0)
☐Combined immunodeficiencies (D81.89)
☐Wiskott-Aldrich syndrome (D82.0)
☐Common variable immunodeficiency (D83.8)
☐Acute Infective Polyneuritis (Guillain-Barre Syndrome) (G61.0)
☐Chronic Inflammatory Demyelinating Polyneuritis (CIDP) (G61.81)
☐Inflammatory Polyneuropathy, unspecified (MMN) (G61.9)
☐Other: ______________________________________/ICD-10: _________

Patient Medical Information

Weight: _______☐lb ☐kg Height: _______☐in ☐cm IgA deficiency: ☐Yes ☐No
Allergies: ____
Is this the patient's first dose of IG? ☐Yes ☐No
If no, Date of last dose: _______________ Next dose due:_______________
Prior IG products received: _____________________________________
Prior reactions to IG: ____
IV access: ☒Peripheral ☐PICC ☐Port ☐Other: ______________________
Does the patient already have an infusion pump? ☐Yes ☐No
Other notes: ____
____

Prescription Information (Please select either the IV or SC order set below)

☐ IVIG Protocol

Immune Globulin Product:
☐Pharmacist to determine
☐Specific formulation required: _______________________

IG dosing:
________g/day for ________ day(s) every ________ weeks
\# of doses: ______________ Refills: __________

Rate of Administration:
☐Pharmacist to determine based on manufacturer guidelines
☐Custom: ____
____

IV Flushing Orders (dispense quantity sufficient):
☐Sodium Chloride 0.9% 5-10mL flush before and after infusion
☐Heparin _____Units/mL flush with _____mL prn to maintain line patency
☐Other: ____

Premedication (dispense quantity sufficient):
☐Acetaminophen 325-650mg PO 30 minutes prior to infusion
☐Diphenhydramine 25-50mg PO 30 minutes prior to infusion
☐Other: ____

Adverse Reaction Orders (to be provided unless otherwise indicated):
Nursing orders: STOP IV and call/page prescriber for all adverse events. May restart infusion at the same or lower rate pending MD approval. For patients showing signs of anaphylaxis immediately call 911 and administer anaphylaxis kit medications per protocol.
Anaphylaxis kit:

- Diphenhydramine: 25mg tablet/capsule (2); 50mg/mL 1mL vial (1)
- Epinephrine auto-injector (2)
  - 0.3mg for patients > 30kg
  - 0.15mg for patients < 30kg
- Sodium Chloride 0.9%: 500mL bag (1), 10mL syringe (4)

Ancillary Supplies/Services (to be provided unless otherwise indicated):

- Ancillary supplies as needed for home infusion administration
- Skilled nursing visits as needed for medication education, administration, and monitoring

☐ SCIG Protocol

Immune Globulin Product:
☐Pharmacist to determine
☐Specific formulation required: _______________________

IG dosing:
________g/day for ________ day(s) every ________ weeks
\# of doses: ______________ Refills: __________

Rate of Administration:
☐Pharmacist to determine based on manufacturer guidelines
☐Custom: ____
____

PRN Medications:
☐Acetaminophen 325mg: 1-2 tablets PO Q4-6 hours prn for headache, fever, or chills (Do not exceed 4 doses/24 hours) Quantity: 120 Refills: PRN
☐Diphenhydramine 25mg: 1-2 tables PO Q4-6 hours prn for itching, rash, or chills (DO not exceed 4 doses/24 hours) Quantity: 120 Refills: PRN
☐Other: ____
Quantity: _______________ Refills: ______________

Anaphylaxis Kit (to be provided unless otherwise indicated):
Patient Instructions: Keep on hand at all times. For allergic reaction, STOP infusion, call 911 immediately, and administer the following medications as instructed:

- Diphenhydramine 25mg: 1-2 tablets PO (#2)
- Epinephrine auto-injector IM (#2)
  - 0.3mg for patients > 30kg
  - 0.15mg for patients < 30kg

Ancillary Supplies/Services (to be provided unless otherwise indicated):

- Ancillary supplies, pump, and home medical equipment needed for administration
- Skilled nursing visits as needed for initial set-up, patient training/education, and ongoing monitoring

Provider Signature: _______________________________________ **Date:** ____________________

My signature for this prescription also authorizes OptiMed Specialty Pharmacy and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process.

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