IVIG INFUSION REFERRAL FORM

V-Care Pharmacy
Specialty + Medical & Surgical Supplies
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Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

JULY 2016

Patient Name First Name Last Name SS# DOB Height Weight ☐ Male ☐ Female
Street Address Apt # City State Zip
Daytime Tel Evening Tel Cell Email
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ V-Care Pharmacy Date Needed
Allergies Comorbidities
Current Medications (if necessary, please fax a complete list)

DIAGNOSIS ☐ Polymiositis (M33.20) ☐ CVID (D84.9) ☐ CIDP (G61.81) ☐ Myathesnia Gravis (G70.0) ☐ Polyneuropathy in diseases classified elsewhere (G63)
☐ Other specified diabetes mellitus with diabetic neuropathy, unspecified (E13.40) ☐ Immune Neuropathy other than CIDP w/o Paraproteinemia (G61.81)
☐ Dermatomyositis (M36.0) ☐ Lambert-Eaton Syndrome, unspecified (G70.80) ☐ Guillian-Barre Syndrome (G61.0) ☐ Other

Insured's Name Relation to Patient Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#
Prescription Card ☐ Yes ☐ No If Yes, Carrier Tel Fax Policy/Group#
Bin# Pcn# RXID# RX Group#

Prescriber's Name Office Contact
Street Address Suite # City State Zip
Tel Fax Email
License# NPI# UPIN# DEA#

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

Does patient already have a line? ☐ Yes ☐ No If yes, type of line **IVIG to be infused via existing line:** ☐ Yes ☐ No
First IVIG Infusion? ☐ Yes ☐ No If yes, IgA level is more than 5 mg/dl: ☐ Yes ☐ No ☐ Not Available
Ig Quantification: IgA, IgG, IgM (prior to 1st IVIG infusion) ☐ Yes ☐ No If no, brand/dose of IVIG: Last infusion Date:
Note: IVIG contains IgA and is contraindicated in IgA deficient patients with antibodies against IgA and history of hypersensitivity.

IVIG (IMMUNOGLOBIN) ORDER: *(IVIG brand will be chosen if not specified)*

IVIG DOSE: g/kg = g (round to nearest vial size) infuse intravenously (Range: 0.2-2 g/kg)
☐ Repeat dose **daily** x consecutive days total, repeat dose: monthly x months ☐ Repeat dose **weekly** x weeks total
☐ Repeat dose **monthly** x months total ☐ Other

SUGGESTED RATE OF INFUSION: ☐ 30 -150 ml/hr as tolerated (Increase rate gradually every 30 min by 20-30 ml/hr) Other

PRE-MEDICATIONS: **TO BE ADMINISTERED 30 MIN PRIOR TO IVIG INFUSION (QTY:PER INFUSION):**
☐ Diphenhydramine 25 - 50 mg PO Dispense:#2 (25 mg) | ☐ Acetaminophen 650 mg PO Dispense:#2 (325 mg)) | ☐ Other QTY: QS

IN THE EVENT OF ANAPHYLAXIS:
- Stop Infusion and call MD & 911
- Diphenhydramine 25 - 50 mg IVP every 4 hours prn (Not to exceed 25 mg/min) QTY: 3 (50 mg)
- Epinephrine (1:1000) 0.4 mg SQ prn anaphylaxis, may repeat every 20 minutes x 2 QTY: 3 amp

Other

SUPPLIES FOR INFUSION (if necessary)
☐ NaCl 0.9% / D5W for flush: flush Line/Port with (3 - 5 ml for PIV and 5-10 ml for Central Line/Port) per nursing agency protocol
(NaCl 0.9% / D5W will be used based on IVIG compatibility)
☐ Heparin for flush (100 Units / ml) (if RN keeps PIVor if needed for Central Line), flush with 3-5 ml per nursing agency protocol
☐ Sterile water for reconstitution of powder to make the requested concentration (for Carimune NF)
☐ Other:

By signing this form and utilizing our services, you are authorizing V-Care Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) **Date**

Please fax completed referral form to **V-Care Pharmacy & Surgical Supplies** at **508.202.9343** or **844.230.6211** Visit us at **WWW.MYVCAREPHARMACY.COM** for online fillable forms.