



<input type="checkbox"/> Orange, CA P: (714) 941-6177 F: (714) 941-6178	<input type="checkbox"/> Burbank, CA P: (818) 848-8112 F: (818) 848-8142	<input type="checkbox"/> Las Vegas, NV P: (702) 825-4900 F: (702) 977-8150
<input type="checkbox"/> Las Vegas, NV P: (702) 790-4404 F: (702) 790-4406	<input type="checkbox"/> Marrero, LA P: (504) 340-5221 F: (504) 340-5228	<input type="checkbox"/> Carson City, NV P: (702) 825-4900 F: (702) 977-8150
<input type="checkbox"/> Allen, TX P: (469) 257-4200 F: (469) 795-9204	<input type="checkbox"/> Memphis, TN P: (901) 560-3580 F: (901) 560-3581	

IV/SQ Ig Referral Form

Patient Information		Prescriber Information	
Patient Name: _____	DOB: __/__/__	Prescriber Name: _____	NPI: _____
Sex: <input type="checkbox"/> Femal <input type="checkbox"/> Male	SS#: ___-___-___	Language: _____	If Shipping to prescriber: <input type="checkbox"/> Initial Fill <input type="checkbox"/> Always <input type="checkbox"/> Never
Allergies: _____	Wt: ___ <input type="checkbox"/> Kg <input type="checkbox"/> Lb	Ht: ___ <input type="checkbox"/> Cm <input type="checkbox"/> In	Address: _____ Apt/Suite: _____
Address: _____	Apt/Suite: _____	City: _____ State: _____ Zip: _____	Phone: _____ Contact: _____
City: _____ State: _____ Zip: _____	Relation: _____	Fax: _____ Alt. Fax: _____	Email Address: _____
Phone: _____ Contact: _____			
Email Address: _____			

INSURANCE INFORMATION (or attach copy of cards)

Medical Plan: _____	Policy #: _____	Policy Holder: _____	Relationship: _____
Prescription Plan: _____	Policy #: _____	Policy Holder: _____	Relationship: _____

Clinical Information

Access Type: Peripheral PICC PORT SCIG

Has patient previously been on IG therapy? No Yes/Brand Infused: _____/Last Infusion: _____

Comorbidities/Risk Factors: Renal Insufficiency Diabetes Heart Disease Thrombotic Event Hypertension

IgA deficiency: Yes No IgA level: ___mg/dL (Date: _____) Does patient have a latex allergy? Yes No

Previously Tried Treatments/Medications for The Condition: _____

Prescription

<input type="checkbox"/> IVIG (Pharmacy to determine)	<input type="checkbox"/> Gammaked 10%	<input type="checkbox"/> SQIG (Pharmacy to determine)
<input type="checkbox"/> Cutaquig 16.5% (SC route)	<input type="checkbox"/> Gamunex-C 10%	<input type="checkbox"/> Octagam 5% 10%
<input type="checkbox"/> Cuvitru 20% (SC route)	<input type="checkbox"/> Hizentra 20% <input type="checkbox"/> PFS <input type="checkbox"/> Vials (SC route)	<input type="checkbox"/> Panzyga 10%
<input type="checkbox"/> Gammagard Liq 10%	<input type="checkbox"/> HyQvia 10% (SC route)	<input type="checkbox"/> Privigen 10%
<input type="checkbox"/> Gammagard S/D <input type="checkbox"/> 5% <input type="checkbox"/> 10%		<input type="checkbox"/> Xembify 20% (SC route)
<input type="checkbox"/> Other: _____		

Dose and Frequency

<input type="checkbox"/> Intravenous Immunoglobulin	<input type="checkbox"/> Subcutaneous Immunoglobulin
<input type="checkbox"/> Loading Dose: ___ gm/kg Over ___ day(s) then	
<input type="checkbox"/> Maintenance Dose: ___ gm/kg Over ___ day(s), every ___ week(s) X ___ cycle(s)	
<input type="checkbox"/> 0.4 gm/kg <input type="checkbox"/> 1 gm/kg <input type="checkbox"/> 2 gm/kg	<input type="checkbox"/> Infuse ___ grams OR ___ mLs
<input type="checkbox"/> Infuse ___ grams IV daily X ___ day(s); repeat every week(s) X ___ cycle(s)	using ___ sites X ___ time(s) per week
<input type="checkbox"/> Other: _____	for ___ month(s)

Hydration and Pre-Medications

Hydration: NaCl 0.9% 250mL to infuse at a rate of 250mL/hr IV before & after infusion as hydration is needed.

Benadryl 25mg capsule: Take 1-2 caps by mouth 30-60 minutes prior to infusion & every 6 hours as needed post infusion.

Benadryl 50mg ampule: Infuse ___mg slow IVP 30 minutes prior to infusion

Tylenol 325mg: Take 1-2 tabs by mouth 30-60 minutes prior to infusion & every 6 hours as needed post infusion.
Not to exceed total daily dose of 3000mg.

Zofran 4mg ODT: Dissolve 1 tab on the tongue every 8 hours as needed for pre & post infusion for nausea and vomiting.

Solu-Cortef: Infuse ___mg slow IVP 30 minutes prior to infusion

Solu-Medrol: Infuse ___mg slow IVP 30 minutes prior to infusion

Flushing Protocol

Sodium Chloride 0.9% 5-10 ml pre and post medications

Heparin ___ Units/mL OR ___ mL as needed

Anaphylaxis Protocol

MILD infusion reactions: (Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated)

Diphenhydramine 25mg caps #4 Sig: Take 1-2 capsules PO Q6H PRN for infusion reactions, NTE total daily dose of 400mg (16 caps/day).

MODERATE infusion reactions: (Stop Infusion, resume at 50% rate when symptoms resolve)

Diphenhydramine 50mg/ml vial #1 Sig: Inject 1ml (=50mg) IV by slow IV push over 3-5 mins PRN for anaphylaxis reaction.

May repeat every 4 hrs, NTE 400mg/24hrs

SEVERE ANAPHYLAXIS *CALL 911* (Stop infusion and remove tubing from access device to prevent further administration)

1. Epinephrine 0.3mg Auto Injector #2 Sig: Remove cap then inject auto-injector intramuscularly in the thigh area and hold for 2 to 10 seconds as needed for anaphylaxis reaction, may administer through clothing if necessary. May repeat in 5-15-minutes.

2. Initiate 0.9% NaCl 500 mL IV x 1

3. Administer CPR if needed until EMS arrives

Ancillary Supplies : As needed for proper administration and disposal of medication

Skilled Nursing Visits: As needed for IV access, administration and proper clinical monitoring

Administration procedures to be followed per pharmacy protocol.

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Deliver to: Home Office Infusion Suite Other: _____

If shipped to prescriber's office or infusion clinic, prescriber accepts on behalf of patient for administration in office or infusion clinic.

By signing this order, I, the prescriber, certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber's Signature _____

Date: __/__/__

* Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.
" Referral forms are not valid in Arizona, providers can phone or electronically send in orders."