pharmacy SPECIALISTS

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Immune Globulin Referral Form

REQUIRED: Demographics & Most recent H&P, Clinical Notes, and Medication List

PATIENT INFORMATION

Patient Name | Date of Birth | Gender ☐ Male ☐ Female

Address

Home Phone | Work Phone | Cell Phone

INSURANCE INFORMATION: Please fax a copy of the insurance card(s) with this form (front and back)

MEDICAL INFORMATION

Weight (kg) | Height | Allergies

Diagnosis | Date

Patient Status ☐ New to Therapy ☐ Continuing Therapy | Next Treatment Date

Line Access ☐ Port ☐ PICC ☐ PIV Other: _____ | Ig Orders ☐ IV ☐ Sub Q

Has the patient received IVIG/SCIg previously? ☐ Y ☐ N If Yes, please list previous product: _____

MEDICATION ORDERS

Loading Dose: _____ grams/kg divided over _____ days **OR** _____ grams/kg for _____ days

Maintenance Dose: _____ grams/kg divided over _____ days **OR** _____ grams/kg for _____ days

Frequency: Repeat dose every _____ week(s) for _____ **Refills:** _____

- Pharmacist to identify clinically appropriate Ig brand and infusion rates. May substitute based upon product availability.
  - If specific brand is required:
    - Brand Name product: _____
    - Prescriber must write Brand Medically Necessary for brand to be dispensed _____
- Infuse entire contents of Ig infusion bag/vial(s) per current dose.
- Pharmacist will round dose to the nearest whole 5 gram vial for IV doses and nearest single-use vial size for Sub Q doses.

Current Medications: _____

ADDITIONAL ORDERS

Pre-Medication Orders: to be administered 15-30 minutes before infusion

☐ Acetaminophen 325mg PO ☐ Normal Saline 500mL IV ☐ Diphenhydramine 25mg PO ☐ Other: _____

Anaphylactic Reaction Orders:

- Diphenhydramine 25mg-50mg IM/IV PRN allergic reaction (adult)
- Epinephrine 1:1000 (mg/ml) PRN severe allergic reaction (based on patient weight)
  - >30kg (>66lbs): Epinephrine 0.3mg IM or subQ; may repeat in 5-15 minutes x 1
  - 15-30kg (33-66lbs): Epinephrine 0.15 IM or subQ; may repeat in 5-15 minutes x 1

Lab Orders: _____

Labs: Required labs to be drawn by ☐ Home Health Nurse ☐ Referring Provider ☐ Other: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, the prescriber is authorizing *Pharmacy Specialists* and its employees to serve as their prior authorization and designated agent in dealing with medical and prescription insurance companies. The prescriber certifies that the use of the indicated treatment is medically necessary, and the prescriber will supervise the patient's treatment.

Prescriber Name | Signature | Date

Prescriber NPI | Phone | Fax | Contact Person