

Immunoglobulin Referral Form

Fax Completed Form To:

Phone:

PATIENT INFORMATION		
Patient Name:	Date of Birth:	Referral Date:
Address:	City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:
Secondary Contact:	Height: Weight:	☐ Male ☐ Female
Patient Diagnosis & ICD-10:		
Allergies:		
PROVIDER INFORMATION		
Physician Name:	Lic.#:	DEA #:
Practice Name:	NPI#:	
Address:	City/State/Zip:	
Office Contact:	Phone:	Fax:
Supervisory Physician (if applicable):		
PLEASE ATTACH		
☐ 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 information required for neurology diagnosis only ☐ Recent BUN & Creatinine results ☐ Diagnostic testing (one or all) to match diagnosis: ☐ Electromyography (EMG) ☐ Nerve Biopsy ☐ Muscle Biopsy ☐ Nerve Conduction Study		
Additional information required for immunology diagnosis only ☐ IG Serum Levels: IgG, IgA, and IgM ☐ Subclass Levels: Ig1, Ig2, Ig3, Ig4 ☐ Recent BUN & Creatinine results ☐ Immunization challenge test results and titers values ☐ Supporting documentation of chronic infection history, hospitalizations & previous treatment		
NURSING & LAB ORDERS		
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.		
Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - ☐ 10units/mL ---OR--- ☐ 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line		
Lab Orders: Lab Date & Frequency:		
PRESCRIPTION ORDERS		
Anaphylaxis Kit: ☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply) ☐ Diphenhydramine _____mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other		
Pre-Medications: ☐ Acetaminophen _____mg PO _____minutes prior to infusion ☐ Solu-Medrol _____mg IV _____minutes prior to infusion (Check all that apply) ☐ Diphenhydramine _____mg ☐ PO ---OR--- ☐ IV infusion _____minutes prior to infusion ☐ Other Pre-Hydration ☐ NS Hydration 250ml-500 ml IV infusion over 30 minutes as needed		
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary		
PRODUCT	PRESCRIPTION INFORMATION	REFILLS
Is this a first dose? ☐ Yes ☐ No If No, when was last dose given? _____ When is patient due for next dose? _____		
☐ IMMUNOGLOBULINS	Administration Route: ☐ IV infusion ---OR--- ☐ SC infusion Dosing/Frequency: _____mg/kg divided over _____days every _____weeks _____mg/kg for one time dose _____mg every _____weeks ☐ RPh Recommended Brand	_____
☐ OTHER		_____
By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.		

Prescriber's Signature
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

Print Name

Date

No MD signature required on this form for infusion therapy. The pharmacist or NP will be sending a fax with prescription order details that must be signed by the physician before this drug can be dispensed.