

IVIG REFERRAL FORM

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card • H&P • Patient Dems • Most Recent Labs • Med List • Current IG Levels

PRIMARY DIAGNOSIS

- | | |
|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> D80.0 Hereditary hypogammaglobulinemia | <input type="checkbox"/> G72.49 Oth inflammatory and immune myopathies, NEC |
| <input type="checkbox"/> D80.1 Nonfamilial hypogammaglobulinemia | <input type="checkbox"/> L13.8 Other specified bullous disorders |
| <input type="checkbox"/> D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses | <input type="checkbox"/> M33.00 Juvenile dermatomyositis, organ involvement unspecified |
| <input type="checkbox"/> D83.9 Common variable immunodeficiency, unspecified | <input type="checkbox"/> M33.10 Other dermatomyositis, organ involvement unspecified |
| <input type="checkbox"/> D89.89 Oth dsrd involving the immune mechanism, NEC | <input type="checkbox"/> M33.13 Other dermatomyositis without myopathy |
| <input type="checkbox"/> G35.A Relapsing-remitting multiple sclerosis | <input type="checkbox"/> M33.20 Polymyositis, organ involvement unspecified |
| <input type="checkbox"/> G61.81 Chronic inflammatory demyelinating polyneuritis | <input type="checkbox"/> M33.22 Polymyositis with myopathy |
| <input type="checkbox"/> G61.82 Multifocal motor neuropathy | <input type="checkbox"/> M33.90 Dermatopolymyositis, unsp, organ involvement unspecified |
| <input type="checkbox"/> G70.00 Myasthenia Gravis without (acute) exacerbation | <input type="checkbox"/> M33.91 Dermatopolymyositis, unsp with respiratory involvement |
| <input type="checkbox"/> G70.01 Myasthenia gravis with (acute) exacerbation | <input type="checkbox"/> Other: _____ |

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: No recommended standard pre-meds for IVIG
 Provider Prescribed: _____

PRIMARY MEDICATION ORDER

- No Brand Preference:**
 No brand preference - Immune Globulin Solution 5%
 No brand preference - Immune Globulin Solution 10%
- If Brand Preference:**
 Alyglo 10%
 Bivigam 10%
 Gamunex-C 10%
- Gammagard Liquid 10%
 Octagam 5%
 Octagam 10%
 Panzyga 10%
- Privigen 10%
 Yimmungo 10%
 Other _____
- Dosing:**
 _____ GRAMS/kg or _____ grams divided equally over _____ days every _____ weeks
 _____ mg/kg or _____ milligrams divided equally over _____ days every _____ weeks
 Other: _____

*Dose will be rounded to the nearest 5g vial size. To prohibit dose rounding, check here

First Dose: Y N Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
 Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy) Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature _____

Date _____