IVIG REFERRAL FORM

BARNERT PHARMACY
"FAST, FRIENDLY, DEPENDABLE SERVICE"

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Paterson, NJ 07514

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Patient Information

Patient Name _____ Today's Date_____ ☐ *NEW Patient* ☐ *CURRENT Patient*

DOB_____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____

Best Phone _____ Email _____

Street Address_____ Apt#_____ City_____ State_____ Zip_____

Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address

Allergies_____

Current Medications including OTC's (*please fax a complete list*)_____

Please Fax Insurance Card(s) both sides

Insured's Name _____

Relation to Patient _____

Primary Insurance _____

ID# _____ Group#_____

Secondary Insurance _____

ID# _____ Group#_____

Ordering Prescriber

Office Contact _____

Street Address _____ Suite #_____

City _____ State_____ Zip_____

Tel _____ Fax _____

Email _____

License#_____

NPI# _____

ICD-10 Code

☐ **C90.0** Multiple Myeloma
☐ **C90.1** Plasma Cell Leukemia
☐ **C91.10** Lymphoid Leukemia
☐ **D69.6** Thrombocytopenia
☐ **D80.0** Hereditary Hypogammaglobulinemia
☐ **D80.1** Nonfamilial Hypogammaglobulinemia
☐ **D80.2** Selective deficiency of IgA
☐ **D80.3** Selective deficiency of IgG Subclasses
☐ **D80.5** Immunodeficiency with Increased IgM
☐ **D81.1** SCID with Low T- and B- Cell Numbers
☐ **D81.2** SCID with Low or Normal B-Cell Numbers
☐ **D81.89** Other combined Immunodeficiencies
☐ **D81.9** Combined Immunodeficiency, Unspecified
☐ **D83.1** CVID w/ Predominant Immunoregulatory T-Cell Disorders
☐ **D83.8** Other Common Var. Immunodeficiencies
☐ **D83.9** Common Var. Immunodeficiency, Unspecified
☐ **E13.40** Other specified diabetes mellitus w/ diabetic neuropathy, unspecified
☐ **D84.9** CVID
☐ **G25.82** Stiff Person Syndrome
☐ **G35** Multiple Sclerosis (MS)
☐ **G61.0** Guillain-Barre Syndrome (GBS)
☐ **G61.81** Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ **G62.9** Other Peripheral Neuropathy
☐ **G63** Polyneuropathy in diseases classified elsewhere
☐ **G70.0** Myasthenia Gravis (MG)
☐ **G70.01** Myasthenia Gravis with (Acute) Exacerbation
☐ **G70.80** Lambert-Eaton Syndrome, unspecified
☐ **L12.0** Pemphigoid
☐ **L10.9** Pemphigus
☐ **M30.3** Kawasaki's syndrome
☐ **M32.9** Systemic lupus erythematosus (SLE)
☐ **M33.20** Polymyositis, Organ Involvement Unspecified
☐ **M33.90** Dermatopolymyositis & Organ Involvement Unspecified
☐ **M36.0** Dermatomyositis
☐ **Q81.9** Epidermolysis Bullosa
☐ **Z41.8** Prophylactic Immunotherapy
☐ **Z94.81** BMT
☐ **Other** _____

Prescription

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: _____

PRE-MEDICATIONS: *To be administered 30 min prior to IVIG Infusion: (QTY: per infusion):* ☐Acetaminophen 650 mg PO
☐Diphenhydramine 25 mg-50 mg ☐Other: _____

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

INTRAVENOUS IMMUNOGLOBULIN Dose ☐0.4 gm/kg ☐1gm/kg ☐2gm/kg ☐____gm
Infuse: ☐IV daily for _____ day(s); repeat every_____ week(s) for_____ cycles Refills: _____
☐Other _____ Refills:_____

SUBCUTANEOUS IMMUNOGLOBULIN Infuse: ☐____gm OR ____ ml using ____ sites ____ time(s) per week for _____
Hydration order: ☐_____ ml NS IV to be infused prior/concurrently with IVIG Refills: _____

ACCESS	**NS HEPARIN**	**100 u/ml** *(If applicable, flush IV access device per Pharmacy protocol)*
Peripheral	1-3ml before/after use	10u/ml 1-2mls after last NS flush
Midline, central (non-port), PICC	NS 5-10 mls before/after use;	10mls after blood draw 10 u/ml 3-5mls after last NS flush; 5mls after blood draw
Implanted Port	5-10mls before/after use;	20mls after blood draw 100 u/ml 5mls after last NS flush; 5mls after blood draw
Tunneled	5-10mls before/after use;	20mls after blood draw 10 u/ml 3- mls after last NS flush. 5mls after blood draw
Groshong PICC, Midline	5-10mls before/after use;	10mls after blood draw NO Heparin needed

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 _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

By signing this form I authorize Barnert Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

_____ **Prescriber's signature** (no stamps) if brand required check this ☐ DAW____ **Date**_____