



Subcutaneous Immune Globulin Patient Referral Form

Admissions Fax # 844-878-6917

Admissions Phone # 855-WE-R-RARE (855-937-7273)

Patient Demographics Information

Patient Name		SSN#	DOB
Patient Address			
Primary Phone	Cellular Phone	Work Phone	
Emergency Contact Name, Relationship		Emergency Contact Phone Number	

Additional Documentation Needed

<input type="checkbox"/> Copy of insurance cards	<input type="checkbox"/> Labs to include IgA level (within 1 year)	<input type="checkbox"/> For immune deficiency, detailed infection history, baseline IgG levels, vaccine responses
<input type="checkbox"/> Patient face sheet w/demographics	<input type="checkbox"/> CBC w/dif, BMP, & CMP	<input type="checkbox"/> Blood type
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Recent vitals including blood pressure	

Patient Insurance Information

Insurance Plan #1		Insurance Plan #2	
Plan Address		Plan Address	
Plan Phone & Fax Numbers		Plan Phone & Fax Numbers	
Subscriber Name	DOB	Subscriber Name	DOB
Policy Number	Group ID	Policy Number	Group ID

Patient Clinical Information

Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (inches)	Weight (lbs.)	Allergies (food/drug)
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Statement of Medical Necessity / Primary Diagnosis

Neurology Referrals	Immunology Referrals
ICD10 Description of diagnosis	ICD10 Description of diagnosis

Medication Information / Prescription and Orders

Medication <input type="checkbox"/> Preferred Product <input type="checkbox"/> No Preference	Dose Loading: _____ gms OR _____ gm/kg given over _____ days Main: _____ gms OR _____ gm/kg (rounded to the nearest vial size) SQ every _____ week(s)	Directions Infuse SQ per manufacturer guidelines OR over _____ hours. Titration rate according to pharmacy protocol.	Quantity / Refills Dispense: 1 months supply, refill x12mos unless otherwise noted <input type="checkbox"/> Other
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First Dose? <input type="checkbox"/> Y <input type="checkbox"/> N	If NO, List Product	Date of last Infusion	Next Dose Due
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Premedications

Give premedication 30 minutes prior to infusion (*generics will be dispensed*)

Diphenhydramine: 25-50 mg po #QS
 Antihistamine: Fexofenadine 180 mg po #QS
 Acetaminophen: 325-650 mg po **OR** _____ mg po #QS

EMLA cream (Lidocaine 2.5% and Prilocaine 2.5%) topically #QS: apply to needle site prior to access PRN for pain upon needle insertion.

RN to instruct patient to hydrate pre/post infusion.

RN to instruct patient to take Diphenhydramine 25-50 mg po (max dose 400 mg/daily) and Acetaminophen 325-650 mg po (max dose 3000 mg/daily) every 4-6 hours for 24-48 hours as needed to prevent/treat post infusion headache.

Other (Physician to specify):
***Physician to be notified if headache persists or worsens.**

Adverse Reaction Orders

In the event of an infusion reaction (ie: fever, chills, backache, headache, rigors) the following orders will be followed and physician will be notified.

Mild reaction: Diphenhydramine 50 mg po x1 dose and slow infusion. If needed, give an additional dose of Diphenhydramine 50 mg po x1 dose (Max 2 doses)

Moderate reaction: Diphenhydramine 50 mg po x1 dose and stop infusion.

Severe reaction (w/breathing problems): CALL 911, and administer Epinephrine IM 0.3 mg or 0.15mg #2 (as det by pt wt).

Prescriber Information

Physician Name		Office Contact	
Practice Address		Practice Phone	
NPI#	License #	DEA#	
Physician Signature Required - Substitution Permitted	Date	Physician Signature Required - Dispense as Written	Date