HERITAGE BIOLOGICS

Intravenous 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

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

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 ☐M ☐F	Height (inches)	Weight (lbs)	Allergies (food/drug)

Statement of Medical Necessity / Primary Diagnosis

Line Access Information:

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

Medication Information / Prescription and Orders

Medication	Dose	Directions	Quantity / Refills
☐ Preferred Product _____ ☐ No Preference	**Loading:** _____ gms OR _____ gm/kg given over _____ days **Main:** _____ gms OR _____ gm/kg *(rounded to the nearest vial size)* IV every _____ week(s)	Infuse IV per manufacturer guidelines **OR** over _____ hours. Titration rate according to pharmacy protocol.	Dispense: 1 months supply, refill x12mos unless otherwise noted ☐ Other

First Dose? ☐Y ☐N	If NO, List Product	Date of last Infusion	Next Dose Due

Premedications

☐ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing and medications per Heritage Biologics policy.
☐ Saline ☐ Heparin 10 u/ml ☐ Heparin 100 u/ml ☐ Sterile field saline (port)

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

- Diphenhydramine: ☐ 25-50 mg po #QS
- Antihistamine: ☐ Fexofenadine 180 mg po #QS
- Methylprednisolone: ☐ 40 mg slow IV push over 5 minutes #QS **OR** 125 mg slow IV push over 5 minutes #QS
- Acetaminophen: ☐ 325-650 mg po **OR** ☐ _____ mg po #QS

☐ EMLA cream (Lidocaine 2.5% and Prilocaine 2.5%) topically #QS: apply to IV site prior to access PRN for pain upon needle insertion.
☐ 0.9% NS 500 mL - 1000 mL IV #QS over 1-2 hours as tolerated daily PRN for hydration and/or headache.
☑ 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; 0.9% NS 250ml #QS, infuse at a rate up to 250 ml/hr as needed.
- ☸ Severe reaction (w/breathing problems): CALL 911, Diphenhydramine 50mg IM #QS x1 dose 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