



# Pediatric 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

<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	
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

Line Access Information:

Neurology Referrals ICD10      Description of diagnosis	Immunology Referrals ICD10      Description of diagnosis
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## 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) IV every _____ week(s)	Directions Infuse IV per manufacturer guidelines <b>OR</b> over _____ hours. Titration rate according to pharmacy protocol.	Quantity / Refills Dispense: 1 months supply, refill x12mos unless otherwise noted <input type="checkbox"/> Other
First Dose? <input type="checkbox"/> Y <input type="checkbox"/> 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 units/mL       Heparin 100 units/mL       Sterile field saline (port)

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

Diphenhydramine:       \_\_\_\_\_ mg po (Diphenhydramine 12.5 mg/5mL Liquid - #1 bottle)

Acetaminophen:       \_\_\_\_\_ mg po (Acetaminophen 160 mg/5 mL oral susp - #1 bottle)

Other: (Physician to specify)

EMLA cream (Lidocaine 2.5% and Prilocaine 2.5%) topically: apply to IV site prior to access PRN for pain upon needle insertion. #1 tube

RN to instruct patient or caregiver to hydrate pre/post infusion.

Other (Physician to specify):

## 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 to moderate reaction: Diphenhydramine 1 mg/kg ( $\leq 25$  kg) or 25 mg ( $> 25$  kg) PO x1 dose and stop infusion until symptoms resolve. Maximum 50 mg/dose. May repeat every 6 to 8 hours. Dispense Diphenhydramine 12.5 mg/5 mL liquid #1 bottle.

Severe reaction (w/breathing problems): CALL 911, and administer Epinephrine IM 0.1 mg, 0.15 mg, or 0.3 mg (**as determined by patient's weight**). #1 kit

## 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

