



Pediatric 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

- 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	
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
First Dose? <input type="checkbox"/> Y <input type="checkbox"/> N	If NO, List Product	Date of last Infusion	Next Dose Due

Premedications

- 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 needle site prior to access PRN for pain upon needle insertion. #1 tube
- 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 (≤ 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