HERITAGE BIOLOGICS

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

- ☸ 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 ☐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

Line Access

RN to start peripheral IV or use existing CVAD. RN to administer catheter flushing and medications per Heritage Biologics policy.

☐ Sodium Chloride 0.9% 5 mL Flush: Flush with 3 mL sodium choride 0.9% IV before and after medication administration or every 24 hours while IV access in place.

☐ Sodium Chloride 0.9% 10 mL STERILE Flush: Flush with 5-10 mL STERILE sodium chloride 0.9% IV as needed for port access.

☐ Heparin Lock **10U/mL** 5 mL Flush: Lock with 3-5 mL heparin **10U/mL** after each use or daily while port accessed.

☐ Heparin Lock **100U/mL** 5 mL Flush: Lock with 5 mL heparin **100U/mL** after each use or daily while port accessed.

Dispense:

Quantity #QS + PRN refills unless otherwise noted

☐ Other

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 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 (≤ 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.

☸ Severe reaction (w/breathing problems): CALL 911; administer Epinephrine IM 0.1 mg, 0.15 mg, or 0.3 mg **(as determined by patient weight)**.

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