HERITAGE BIOLOGICS

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

Statement of Medical Necessity / Primary Diagnosis

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

Medication Information / Prescription and Orders

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

First Dose? ☐Y ☐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 topical cream (Lidocaine 2.5% and Prilocaine 2.5%): apply to SQ needle site prior to access PRN for pain upon needle insertion.

☑ Instruct patient or caregiver to hydrate pre/post infusion.

☐ Other (Physician to specify):

Quantity / Refills

Dispense:

Quantity #QS + PRN refills unless otherwise noted

☐ Other

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 pause infusion until symptoms resolve. May repeat every 6 to 8 hours. Maximum 50 mg/dose. Dispense Diphenhydramine 12.5 mg/5 mL liquid.

☸ 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 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