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 ICD10 Description of diagnosis	Immunology Referrals 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)* SQ every________________week(s)	Infuse SQ 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

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

Diphenhydramine:	☐ 25-50 mg PO
Antihistamine:	☐ Fexofenadine 180 mg PO
Acetaminophen:	☐ 325-650 mg PO **OR** ☐ ______________ mg PO

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

☑ 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.
Notify physician if headache persists/worsens.

☐ 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 reaction: Pause infusion and administer Diphenhydramine 50 mg PO x1 dose. If needed, give an additional dose of Diphenhydramine 50 mg PO x1 dose (Max 2 doses). Resume infusion once symptoms resolve.
- ☸ Moderate reaction: Diphenhydramine 50 mg PO x1 dose and stop infusion.
- ☸ Severe reaction (w/breathing problems): CALL 911; administer Epinephrine IM 0.3 mg or 0.15mg **(as determinded 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