Subcutaneous Immune Globulin Patient Referral Form

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

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 ☐ 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?	If NO, List Product	Date of last Infusion	Next Dose Due
☐Y ☐N			

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