HERITAGE BIOLOGICS

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	Dosing	Quantity / Refills
☐ Preferred Product	☐ **Loading Dose**: _____ g (____ g/kg) IV given over ____ days (_____ g/day). Infuse IV per manufacturer guidelines OR over _____ hours.	Dispense: 1 months supply, refill x12mos unless otherwise noted
☐ No Preference	☐ **Maintenance Dose**: _____ g (____ g/kg) IV every ____ weeks. Infuse IV per manufacturer guidelines OR over _____ hours. *All rates to be titrated according to pharmacy protocol.	☐ 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% 10 mL Flush: Flush with 2-10 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 100 units/mL 5 mL Flush: Lock with 5 mL heparin 100 units/mL after each use or daily while port accessed.

Quantity / Refills

Quantity #QS + PRN refills unless otherwise noted

☐ Other

Premedications

☐ Give premedication(s) 30 minutes prior to infusion

Acetaminophen:	☐ 325-650 mg PO **OR** ☐ _____ mg PO	
DiphenhydrAMINE:	☐ 25-50 mg PO	
Fexofenadine:	☐ 180 mg PO	
MethylPREDNISolone:	☐ 40 mg slow IV push over 5 minutes	**OR** ☐ 125 mg slow IV push over 5 minutes

Ancillary Orders

☐ Lidocaine 2.5% and Prilocaine 2.5% topical cream [PRN]: Apply to IV site prior to access PRN for pain upon needle insertion.

☐ Sodium Chloride 0.9% [PRN]: Infuse _____ mL IV wide open, as tolerated, PRN for hydration and/or headache. (RN assessment required if administered.)

☐ DiphenhydrAMINE 25mg cap [POSTMED]: Take 25-50 mg PO (max dose 400 mg/daily) q4-6hr for 24-48hr PRN to prevent/treat post-infusion headache. Notify Physician if headache persists/worsens.

☐ Acetaminophen 325mg tab [POSTMED]: Take 325-650 mg PO (max dose 3000 mg/daily) q4-6hr for 24-48hr PRN to prevent/treat post infusion headache. Notify Physician if headache persists/worsens.

☐ Other (provider 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 reaction: Give diphenhydrAMINE 50 mg PO x1 dose and slow infusion. If needed, give an additional dose of diphenhydrAMINE 50 mg PO x1 dose (Max 2 doses).
- ☸ Moderate reaction: Give diphenhydrAMINE 50 mg po x1 dose and stop infusion; Sodium Chloride 0.9% 250mL IV wide open as needed.
- ☸ Severe reaction (w/breathing problems): Stop infusion, call 911, and give diphenhydrAMINE 50mg IM x1 dose and EPINEPHrine IM 0.3 mg or 0.15mg. (as det. by patient weight)

Prescriber Information

Physician Name		Office Contact	
Practice Address			
NPI#	License #	Practice Phone	
Physician Signature Required - Substitution Permitted	Date	Physician Signature Required - Dispense as Written	Date