

## **Subcutaneous Immune Globulin Patient Referral Form**

Admissions Fax # 844-878-6917

Admissions Phone # 855-WE-R-RARE (855-937-7273)

	CIALTY PHARMA				Admission	ns Phone # 855-WE-	K-KAKE (855-	937-72	(73)		
	graphics Infor	mation									
Patient Name							SSN#		DOB		
Patient Address									Ļ		
r dilette / tadi ess											
Primary Phone				Cellular Phone			Work Phone				
							- 6	N			
Emergency Contact	Name, Relationship	)					Emergency Contact	: Phone Nu	umber		
Additional Do	cumentation I	Needed									
- Copy of insurance		Vecaca		- Labs to	- Labs to include IgA level (within 1 year)			iency, deta	ailed infection	on	
- Patient face sheet w/demographics				• , ,			history, baseline Igo	• •			
- History and Physic	cal			- Recent v	vitals including blood	d pressure	- Blood type				
	ance Informati	on				-1 ::-2					
Insurance Plan #1					!	Insurance Plan #2					
Subscriber Name				DOB		Subscriber Name	ber Name DOB				
Subscriber Name			1	БОВ	!	Subscriber Name					
Policy Number			Group ID			Policy Number		Group ID			
•			1		,			•			
Patient Clinica	al Information										
Gender	Height (inches)	Weight (II	os.)	Allergies	(food/drug)						
$\Box$ M $\Box$ F											
	<b>Medical Neces</b>	ssity / P	rimary	Diagno	osis						
Neurology Ref				Immunology Re							
ICD10 Description of diagnosis					!	ICD10 Description	tion of diagnosis				
	· / 2										
	formation / P	rescript	T-	d Order	S	•		-	/ = 61		
Medication			Dose		,	Directions				ntity / Refills	
☐ Preferred Produc	:t		Loading:	gm	ns ORgm/kg					pense: nonths supply, refill x12mos	
				given över gms C	days OR gm/kg	over hours. Titration rate according to ph			s supply, refi herwise not		
□ Na Braforonco					nearest vial size)	protocol.	□ Other			24	
☐ No Preference			SQ every	<u>/</u>	week(s)				-		
	If NO, List Product						Date of last Infusion	n	Next Dose	Due	
□Y □N								10	/ 5 . (.)		
Premedication					·				ity / Refil	ls	
•	tion 30 minutes pric	or to infusi ا 25-50 🗆		ics will be	dispensed)		Dispense: Quantity #QS + PRN refills unless otherwise noted			ofills	
Dipnenny Antihistar	rdramine: mine:		ing PO enadine 18	₹0 mg PO							
Acetamin					mg P	0		☐ Other			
☐ EMLA topical cre	eam (Lidocaine 2.5%	and Priloc	caine 2.5%			r to access PRN for pain upon r	needle insertion.				
•	itient to hydrate pre			1	/ 1 11						
•		,			0, 1,	) and Acetaminophen 325-650 ost infusion headache.	) mg PO				
	g/daily) every 4-6 no neadache persists/w		48 Hours	as neeucu	to prevent/treat po	St Ifiiusion neadache.					
☐ Other (Physician		0.505.									
	. ,,										
Adverse React											
	•	fever, chill	is, backacl	ne, headac	che, rigors) the follo	wing orders will be followed					
and physician will b		· ' Div	- 1 buder	:	DO1 doco 16 no.		- 6				
					mg PO x1 dose. If nee I once symptoms rese	eded, give an additional dose o	OŤ .				
	n: Diphenhydramine					oive.					
	• •	_				or 0.15mg (as determined by pa	atient weight).				
Prescriber Info	ormation										
Physician Name						Office Contact					
Practice Address							Practice Phone				
Plactice Address							Tradition Thomas				
NPI#				License #			DEA#				
Dhysisian Signature	Required - Substitu	tion Darm	:++od	Щ	Thata	Physician Signature Required	Dispanso as Writte		Ir	ate	
Physician signature	Kequireu - Substitu	tion reini	tteu	ļ	Date	Physician Signature nequired	- Dispense as write	311	٦	ate	
				,	1						