

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 (ontact Phone Number			
Additional Do	cumentation I	Needed									
				- Labs to include IgA level (within 1 year)			- For immune deficiency, detailed infection				
· • • • • • • • • • • • • • • • • • • •				-	diff, BMP, & CMP vitals including blood	d pressure	history, baseline IgG levels, vaccine responses - Blood type				
	ance Informati	on									
Insurance Plan #1				Insurance Plan #2							
Subscriber Name				DOB		Subscriber Name		DOB			
subscriber Name				БОВ		Subscriber Name	Job				
Policy Number Group			Group ID	Policy Number			Group ID)		
Patient Clinic	al Information										
Gender	Height (inches)	Weight (I	bs.)	Allergies	(food/drug)						
□M □F	Danding Disco	: / 5	· · · · · ·	Diam							
Statement of Medical Necessity / Primary Diagnosis Neurology Referrals Immunology Referrals											
ICD10 Description of diagnosis							escription of diagnosis				
	nformation / P	rescript	T -	d Order	'S			1 -			
Medication Dose					"	Directions		Quantity / Refills			
						·		Dispense:			
					days			1 months supply, refill x12mos unless otherwise noted			
(round				: gms OR gm/kg Titration rate according punded to the nearest vial size) protocol.			□ Other		nei wise no	teu	
☐ No Preference SQ every				· -							
First Dose?	If NO, List Product						Date of last Infus	sion	Next Dose	Due	
Premedications									tity / Refills		
Give premedication 30 minutes prior to infusion (generics will be dispensed)								Dispense: Quantity #QS + PRN refills			
Diphenhydramine:								unless otherwise noted			
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):											
A di	tion Ondone										
Adverse Reac		fever chil	ils hackarl	he heada	che rigars) the fallo	wing orders will be followed					
and physician will b	•	iever, cilii	is, backacı	ie, riedua	crie, rigors, trie rollo	wing orders will be followed					
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											
•	. mg, 0.15 mg, or 0.3	•			nt wt).						
Prescriber Inf	ormation					Lacci a					
Physician Name						Office Contact					
Practice Address						Practice Phone					
NPI#				License #	:		DEA#				
Physician Signature	e Required - Substitu	tion Perm	itted		Date	Physician Signature Required	- Dispense as Wr	itten	I	Date	
, sician signature	quirea Jubblitu					, sician signature nequireu	Dispense us Wi				