

Immune Globulin Referral Form

Phone: 1.877.674.9700

Fax: 1.877.402.4042

Patient Name: _____

Address: _____

DOB: _____ Phone (H) _____

(W) _____ (C) _____

SS# _____ HT: _____ WT: _____ Sex: M F

Patient Email address: _____

Does Patient have Medicare? Yes No Unknown

Medicare Number: _____

Medical Insurance: _____

Member ID _____

Group Name: _____ Group # _____

Policy Holder: _____ Relationship _____

Insurance Phone: _____

Pharmacy Benefit Manager: _____

BIN # _____ Group # _____

Emergency Contact or Parent: _____

Emergency Contact Phone: _____

Medication Orders: *(Please check the following)*

- IVIG Dose: _____ grams/ kg / day X _____ days.
Or _____ grams/day X _____ days.
Interval (frequency of therapy): _____
Refills: X _____

Pre-Meds: 25-50 mg Benadryl PO and 1000 mg Tylenol PO

IV Steroids: _____

Dose: _____ Pre / Post

IV Hydration: _____ Pre / Post

Anaphylaxis Kit per protocol

Has the patient received immune globulin previously? Y N

Labs / Other Meds: _____

Anticipated Start Date: _____

Diagnosis: *(Please check one of the following)*

- 357.81 (CIDP) Chronic Inflammatory Demyelinating Polyneuropathy
- 333.91 Stiff Person Syndrome
- 358.0 Myasthenia Gravis
- 340.0 Multiple Sclerosis
- 357.0 Guillain-Barre Syndrome
- 710.4 Polymyositis
- 710.3 Dermatomyositis
- 356.4 Multifocal Motor Neuropathy
- 279.06 Common Variable Immunodeficiency (CVID)
IgG Level: _____ Date: _____
- 279.00 Hypogammaglobulinemia
IgG Level: _____ Date: _____
- 287.3 Thrombocytopenia (ITP)
Plt Count: _____ Date: _____
- Other: _____
ICD-9 Code _____

Prescribing Physician Information

Name: _____

Address: *(Please include facility name)*

Email address _____

Phone: _____ Fax: _____

License#: _____ NPI #: _____

Specialty: _____

Physician Signature: _____

Referral Date: _____ Referral Time _____

Referred by (Name): _____

Phone / Extension _____