Pharmacy Name: Phone:
Address: Fax:
City/State/Zip: Email:

Immunoglobulin Referral Form

Please attach copy of insurance card (front and back)

Last Name: First Name: DOB:
Address:
City: State: Zip: Sex: ○M ○F
Phone: SSN #:

Insurance Plan

Insurance Plan: Insurance Plan:
Policy #: Policy #:
Plan #: Plan #:

Practice:
Address:
City: State: Zip:
Prescriber Name:
Prescriber NPI:
Nurse/Key Contact:
Phone:
Fax: Email:

Diagnosis and Clinical Information

Please attach clinical/progress notes, labs, test supporting primary diagnosis

Allergies:

Weight: Height:

☐ IV access (for IVIg patients only):

☐ Nurse to place PIV prior to therapy

Neuromuscular Diagnosis:	ICD-10
☐ Chronic inflammatory demyelinating polyneuropathy (CIDP)	G61.81
☐ Guillain-Barré syndrome (GBS)	G61.0
☐ Multifocal motor neuropathy	G61.82
☐ Myasthenia gravis (MG)	G70.0
☐ Myasthenia gravis with (acute) exacerbation	G70.01
☐ Autoimmune encephalopathy	G04.81
☐ Inflammatory neuropathies	G61.89
☐ Relapsing remitting multiple sclerosis (RRMS)	G35
☐ Stiff person syndrome	G25.82
Other:	
☐ Idiopathic thrombocytopenic purpura	D69.3
☐ Dermatopolymyositis	M33.90
☐ Polymyositis	M33.20

Immune Deficiency Diagnosis:	ICD-10
☐ CVID with predominant immunoregulatory T-cell disorders	D83.1
☐ Combined immunodeficiency, unspecified	D81.9
☐ Common variable immunodeficiency, unspecified	D83.9
☐ Hereditary hypogammaglobulinemia	D80.0
☐ Immunodeficiency with increased IgM	D80.5
☐ Nonfamilial hypogammaglobulinemia	D80.1
☐ Other combined immunodeficiencies	D81.89
☐ Other common variable immunodeficiencies	D83.9
☐ Pemphigoid	L12.0
☐ Pemphigus	L10.9
☐ SCID with low or normal B-cell numbers	D81.2
☐ SCID with T- and B-cell numbers	D81.1
☐ Selective deficiency of IgG subclasses	D80.3
☐ Specific antibody deficiency	D80.6
☐ Systemic lupus erythematosus (SLE)	M32.9

Please draw:

☐ CBC/diff ☐ CMP ☐ IgG with subclasses 1-4 ☐ Quant. Ig

Frequency:

Anaphylaxis protocol:

☐ PER pharmacy protocol
☐ PER prescriber protocol:

Flushing protocol:

☐ PER pharmacy protocol
☐ PER prescriber protocol:

Notes:

Prescription Information

Product:

☐ Pharmacist to determine:
☐ Physician-branded:

☐ **Intravenous immunoglobulin**
○ 0.4 gm/kg ○ 1gm/kg ○ 2 gm/kg ○ ____ grams

Infuse: ☐ IV daily x ____ days(s); repeat every ____ week(s) ____ cycles
☐ Other:

☐ **Subcutaneous immunoglobulin**

Infuse ____ grams OR ____ mls using ____ sites ____ time(s) per week for ____ months.

Hydration order: mls NSiv to be infused prior/post IVIg

☐ **Pre-medications:** acetaminophen 650mg PO 30 mins prior to infusion
diphenhydramine 25mg PO 30 mins prior to infusion

☐ **Other pre-medications:**

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature:

Date:

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

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