

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

## Immunoglobulin Referral Form

Please attach copy of insurance card (front and back) | Please attach clinical/progress notes, labs, test supporting primary diagnosis

Last Name:		First Name:		DOB:	Practice:
Address:				Address:	
City: State: Zip:		Phone:		Sex: M F	City: State: Zip:
SSN #:				Prescriber Name: Prescriber NPI:	
Insurance Plan: Policy #: Plan #:		Nurse/Key Contact: Phone: Fax: Email:			
Insurance Plan: Policy #: Plan #:		Weight: Height: Allergies:			

### Diagnosis and Clinical Information

Neuromuscular Diagnosis	ICD-10	Immune Deficiency Diagnosis	ICD-10
Chronic inflammatory demyelinating polyneuropathy (CIDP)	G61.81	CVID with predominant immunoregulatory T-cell disorders	D83.1
Guillain-Barré syndrome (GBS)	G61.0	Combined immunodeficiency, unspecified	D81.9
Multifocal motor neuropathy	G61.82	Common variable immunodeficiency, unspecified	D83.9
Myasthenia gravis (MG)	G70.0	Hereditary hypogammaglobulinemia	D80.0
Myasthenia gravis with (acute) exacerbation	G70.01	Immunodeficiency with increased IgM	D80.5
Autoimmune encephalopathy	G04.81	Nonfamilial hypogammaglobulinemia	D80.1
Inflammatory neuropathies	G61.89	Other combined immunodeficiencies	D81.89
Relapsing remitting multiple sclerosis (RRMS)	G35	Other common variable immunodeficiencies	D83.9
Stiff person syndrome	G25.82	Pemphigoid	L12.0
Idiopathic thrombocytopenic purpura	D69.3	Pemphigus	L10.9
Dermatopolymyositis	M33.90	SCID with low or normal B-cell numbers	D81.2
Polymyositis	M33.20	SCID with T- and B-cell numbers	D81.1
Systemic lupus erythematosus (SLE)	M32.9	Selective deficiency of IgG subclasses	D80.3
Other:		Specific antibody deficiency	D80.6

#### Notes / Labs

CBC/diff	<input type="checkbox"/> PER pharmacy protocol <input type="checkbox"/> PER prescriber protocol:	CMP	<input type="checkbox"/> PER pharmacy protocol <input type="checkbox"/> PER prescriber protocol:
IgG with subclasses 1-4	Quant. Ig   Frequency:		

### Prescription Information

<b>Product:</b> <input type="checkbox"/> Intravenous immunoglobulin <input type="checkbox"/> Subcutaneous immunoglobulin	
<b>Infuse:</b> <input type="checkbox"/> 0.4 gm/kg <input type="checkbox"/> 1gm/kg <input type="checkbox"/> 2 gm/kg <input type="checkbox"/> grams IV daily x _____ days(s); repeat every _____ week(s) x _____ cycles <input type="checkbox"/> Pharmacist to determine <input type="checkbox"/> Physician branded: Other:	<b>Infuse grams OR mls using</b> _____ sites _____ time(s) per week for _____ months. Hydration order: _____ mls NS IV to be infused prior/post IVIg IV access (for IVIg patients only): <input type="checkbox"/> Nurse to place PIV prior to therapy Please draw:
<b>Pre-medications:</b> <input type="checkbox"/> acetaminophen 650mg PO 30 mins prior to infusion <input type="checkbox"/> diphenhydramine 25mg PO 30 mins prior to infusion Other pre-medications:	<b>Anaphylaxis protocol:</b>  <b>Flushing protocol:</b>

I authorize Fannin Infusion Pharmacy 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 Fannin Infusion Pharmacy.

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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