Date Shipment Needed: _____Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

IVIG HOME INFUSION REFERRAL FORM

PATIENT INFORMATION							
Patient Name:			DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.	
SSN:	Phone:	Allergies:					
Address:			City:	State:	Zip:		
Emergency Contact:		Phone:		❑**Please attach demographic information**			
PRESCRIBER INFORMATION							
Prescriber:		NPI:	DEA:	State Lic:			
Supervising Physician:			Practice Name:				
Address:			City:	State:	Zip:		
Phone:	Fax:		Key Office Contact:	Phone:			

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis, choose one:

❑Guillian-Barre Syndrome
❑CIDP & Immune Neuropathies with Paraprotenemia
❑Immune Neuropathy other than CIDP without Paraproteinemia
❑CIDP
❑Vasculitic Neuropathy
❑CVID
❑Multifocal Motor Neuropathy
❑Myasthenia Gravis
❑Lambert-Eaton Myasthenic Syndrome
❑Polymyositis
❑Dermatomyositis
❑Diabetic Proximal Neuropathy
❑Others_____

- Does patient already have a line? ❑Yes ❑No If yes, type of line _____IVIG to be infused via the existing line: ❑Yes ❑No
- First IVIG Infusion: ❑Yes, if yes, IgA level is more than 5 mg/dl: ❑Yes ❑No ❑Not Available → ❑Ig Quantitation: IgA, IgG, IgM (prior to 1st IVIG infusion)
  ❑No, if no, brand/dose of IVIG: _____Last infusion Date:_____

Note: IVIG contains IgA and is contraindicated in IgA deficient patients with antibodies against IgA and history of hypersensitivity.

INSURANCE INFORMATION

❑**Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑**Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

IVIG (IV Immunoglobulin) Order: _____
**Will choose the IVIG brand if not specified*
IVIG dose: _____ grams/kg = _____ grams (rounded to the nearest vial size) infuse intravenously
Range: 0.2-2 grams/kg)
❑Repeat dose daily x _____ consecutive days total, repeat dose: ❑Monthly x _____ months ❑Other: _____
❑Repeat dose weekly x _____ weeks total
❑Repeat dose monthly x _____ months total
❑Other: _____

Suggested Rate of Infusion:
❑30-150 mL/hr as tolerated by patient (increase rate gradually every 30 minutes by 20-30 mL/hr)
❑Other: _____

Pre-Medications: To be Administered 30 Minutes Prior to IVIG Infusion (QTY: Per Infusion)
❑Diphenhydramine 25-50 mg PO, dispense #2 (25 mg)
❑Acetaminophen 650 mg PO, dispense #2 (325 mg)
❑Other: _____

Procedure for Anaphylaxis
STOP infusion and call MD and 911
❑Diphenhydramine 25-50 mg IVP every 4 hours prn (rate to not exceed 25 mg/min.) QTY:_____ Refills:_____
❑Epinephrine (1:1000) 0.4 mg SQ prn anaphylaxis, may repeat every 20 minutes x 2 QTY: 3 amp Refills:_____
❑Other: _____ QTY:_____ Refills:_____

Supplies for Infusion
❑NaCl 0.9%/ D5W for flush: flush Line/Port with (3 – 5 mL for PIV and 5-10 ml for Central line/Port) per nursing agency protocol QTY: QS Refills:_____
(NaCl 0.9% or D5W will be used based on IVIG compatibility)
❑Heparin for flush (100 Units/ml) (if RN keeps PIV or if needed for Central Line), flush with 3 – 5 ml per nursing agency protocol QTY:_____ Refills:_____
❑Sterile water for reconstitution of powder to make the requested concentration (for Carimune NF) QTY:_____ Refills:_____
❑Other: _____ QTY:_____ Refills:_____

Prescriber's Signature: _____ ❑ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through the receiving pharamcy, this prescription shall be forwarded to an eligible pharmacy.

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