HealthQuest Infusion & Specialty

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IVIG REFERRAL FORM

E-SCRIPTS: NCPDP# 5902944 NPI# 1720383003

ACHC ACCREDITED

DATE ____________ DATE NEEDED ____________

SHIP TO: ☐ Patient ☐ Physician's Office ☐ HealthQuest Infusion

Please fax completed form along with copy of patient's insurance cards and any labs to 866.612.3437

Patient Name ______________________________

Patient Address ______________________________

City ____________ State ________ Zip ________

Day Phone ____________ Work Phone # ____________

Cell Phone ____________ E-mail ____________

Date of Birth ____________ SS # ____________

☐ Female

☐ Male

Prescriber's Name ______________________________

License # ____________ DEA # ____________

NPI # ____________ UPIN # ____________

Practice Name ______________________________

Office Contact ______________________________

Address ______________________________ Suite # ________

City ____________ State ________ Zip ________

Phone ____________ Fax ____________

DIAGNOSIS

Patient: Wt.__________ Ht.__________ Allergies: ☐ Latex ☐ Other, specify ______________________________

ICD-10 DIAGNOSIS CODE

☐ B20 HIV

☐ C91.1 Chronic Lymphocytic Leukemia

☐ D80.0 Bruton's X-Linked Agammaglobulinemia

☐ D80.1 Hypogammaglobulinemia

☐ D80.3 Other Selective Immunoglobulin Deficiency

☐ D80.4 Selective IgM Deficiency

☐ D80.5 Hyper IgM

☐ D81.9 Combined Immunodeficiency, unspecified

☐ D82.0 Wiskott-Aldrich Syndrome

☐ D83.8 Other Deficiency of Humoral Immunity

☐ D83.9 CVID

☐ G61.81 CIDP

☐ Other: ______________________________

PRESCRIPTION

Route of Administration ☐ IV ☐ SC ☐ IM ☐ IG Product ______________________________

Dose ____________ g/kg/day x ____________ Days OR ____________ g/day x ____________ days

# of Refills ____________ **For IVIG: does patient already have a line?** ☐ Yes ☐ No

IVIG to be infused in existing line: ☐ Yes ☐ No **First IVIG treatment?** ☐ Yes ☐ No Rate of infusion: ____________

Pre-medications to be given 30min prior to infusion:

☐ Diphenhydramine 25–50mg PO ☐ Acetaminophen 325–650mg PO ☐ Other: ______________________________

Adverse Reaction Epinephrine:

☐ Pt. weighs ≥ 30kg: inject 0.3mg IM PRN for adverse reaction to IVIG ☐ Pt. weighs 15–30kg: inject 0.15mg IM PRN for adverse reaction to IVIG

Infusion Supplies:

☐ NaCl 0.9% flush line/port with (3–5mL for PIV and 5–10mL for central line/port) ☐ Heparin for flush (100 units/mL)

☐ Needles, syringes, and ancillary supplies required to administer medication ☐ Other: ______________________________

ADVERSE REACTION ORDERS: Dispense 1 dose of each medication below to keep at patient's home. In the event of an infusion reaction (ie fever, chills, backache, headache, rigors) the following orders will be followed and physician will be notified. **Note:** For mild Immune Globulin reactions, patient may be treated and infusion resumed at a slower rate. STOP IVIG infusion. Infuse main line NaCl 0.9% at 20mL/hr to keep line open, may increase to 100–250mL/hr for hydration. May give the following if stopping infusion does not resolve symptoms:

1) Dipenhydramine: 50mg slow IV push over 3–5 min.
2) Methylprednisolone: 125mg (OR ______mg) slow IV push over 5 min.
3) Acetaminophen: 325–650mg (OR ______mg) PO at onset of symptoms.
4) Ondansetron: 4mg slow IV push over 5 min.
5) Epinephrine Pen: by weight for use IM in anaphylactic reaction. EMS/911 will be called if used.

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) ______________________________ **DATE** ____________

IMPORTANT NOTICE: This fascimile is intended to be delivered to the named addressee and may contain material that is confidential, privileged, propietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee.