

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

Immunoglobulin Referral Form				
Patient Name		Home Phone		
Date of Birth		Mobile or Work Phone		
Patient Home Address		City	State Z	ip
Primary Insurance Name				
Primary Insurance ID Primary Insurance Group				
Insured Name		Insured DOB		
Secondary Insurance Name		Insurance ID Insurance Group		
Secondary Insurance ID		Secondary Insurance Group		
		NPI		
Ordering Physician's Name				
Address		City	State Z	ip
Phone	Fax			
Please fax the following information: History and Physical Pertinent Lab Work Front & Back copy(s) of patient's insurance card(s)				
Prescription Prescription				
Intravenous Immunoglobulin Subcutaneous Immunoglobulin				
0.4 gm/kg 1 gm/kg 2 gm/kg grams Infuse grams OR mls using sites				
Infuse: IV daily x day(s); repeat every week(s) x cy	time(s) per week for months.			
Other:				
Hydration order: mls NSiv to be infused prior/post IVIG.				
Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion  Other Pre-medications:  Diphenhydramine 25mg PO 30 mins prior to infusion				
Clinical Information				
Patient Weight Height Allergies				
IV access [for IVIGg patients only]: Nurse to place PIV prior to therapy				
Diagnosis	ICD-10	Diagnosis		ICD-10
Neuromuscular:	Immune Deficiency:			
		CVID w/ Predominant Immunoregulators Combined Immunodeficiency, Unspecifi	-	
		Common variable Immunodeficiency, Unspecified		D83.9
Myasthenia Gravis (MG)		Hereditary Hypogammaglobulinemia		D80.0
Myasthenia Gravis with (Acute) Exacerbation G70.01 Immunodeficiency with Increased IgM  Autoimmune Encephalopathy G04.81 Nonfamilial Hypogammaglobulinemia			D80.5	
Autoimmune Encephalopathy		Nonfamilial Hypogammaglobulinemia		D80.1
Inflammatory Neuropathies		Other Combined Immunodeficiencies		D81.89
Relapsing Remitting Multiple Sclerosis (RRMS)			D83.9	
Stiff Person Syndrome G25.82 Pemphigoid Other: Pemphigus		L12.0 L10.9		
Idiopathic Thrombocytopenic Purpura	Pemphigus  D69.3 SCID with Low or Normal B-Cell Numbers		D81.2	
Dermatopolymyositis	M33.90	SCID with T- and B- Cell Numbers		D81.1
Polymyositis	M33.20	Selective Deficiency of IgG Subclasses		D80.3
		Specific Antibody Deficiency		D80.6
		Systemic Lupus Erythematosus (SLE)		M32.9
Please Draw: Anaphylaxis Protocol:				
Please Draw:	PER Pharmacy Protocol			
CBC/diff CMP IgG w/ subclasses 1-4 Quant. Ig Frequency:		PER Prescriber Protocol:		
	_	T EN T TOSONIDOT T TOTOGOS.		-
Notes:  Flushing Protocol:				
· ·				
PER Pharmacy Protocol				
PER Prescriber Protocol:				
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.  Date:				

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

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