☐ Home Infusion ☐ Alternate Site of Care

IVIG - NEUROLOGY/IMMUNOLOGY REFERRAL FORM

vitalcare of SOUTH DALLAS REP

NPI #: 1871219683 **TEL:** 945-212-3707 **FAX:** 866-790-3580

Patient Name ______________________ SSN (last 4):__________ DOB __________ ☐ Male ☐ Female

Street Address ______________________ Apt# ______ City ______________ State ______ Zip ________

Daytime Tel ______________ Cell ______________ Email ______________________ Height ______ Weight ______

Ship to Patient at ☐ Home ☐ Physician Office Primary Language ☐ English ☐ Spanish ☐ Other__________

Allergies ______________________________ ☐ PMH (attached) ☐ Current Medications (attached)

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER NAME AND NPI#
______________________________ #______________

Insured's Name ______________________ Relation to Patient ______________________

Insured's Phone Number ______________ Prescription Card ☐ Yes ☐ No If Yes, Carrier ______________

Policy/Group# ______________ Bin# ______________ Pcn# ______________

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

ICD-10 Diagnosis:

☐ **D80.1** Nonfamilial Hypogammaglobulinema
☐ **D80.3** Selective deficiency of immunoglobulin G [IgG] subclasses
☐ **D83.9** Common Variable Immunodeficiency, unspecified
☐ **G04.81** Other encephalitis and encephalomyelitis
☐ **G35** Multiple Sclerosis
☐ **Other ICD-10** _______ ______________________
☐ **G61.0** Gullian-Barre Syndrome
☐ **G61.81** CIDP
☐ **G61.82** Multifocal Motor Neuropathy
☐ **G70.00** Myasthenia gravis without (acute) exacerbation
☐ **G70.01** Myasthenia gravis with (acute) exacerbation

IGA Deficiency: ☐ Check box if patient requires low IGA product ☐ Attach recent labs

PRESCRIPTION

Is this the first dose? ☐ Yes ☐ No

If no: List product______________ Date of last infusion______________ Next dose due______________

Dose based on ☐ Actual Body Weight* ☐ Adjusted Body Weight* ☐ Ideal Body Weight* *rounded to nearest 5 grams

Ship to Patient at ☐ Home ☐ Physician Office

PHYSICIAN ORDERS

☐ IVIG Therapy: Infuse IVIG ______ GMS or ______ gm/kg IV over ______ hours or as tolerated.

If not specified, will follow company policy for IVIG administration.

Frequency: ______________________________ QTY: ________ # of Refills: ________

☐ Pharmacy to select IVIG Product ☐ Specific Brand desired, please specify: ______________________

☐ Other Therapy: Infuse ______________________ Dose______________ Frequency ______________________

Route of Administration: ______________________ Infusion Rate: ______________ QTY:________ # of Refills: ________

☐ Pharmacy to select IVIG Product ☐ Specific Brand desired, please specify: ______________________

PRE-MEDICATIONS (administer 30 minutes prior to infusion)

The quantity and refills for pre/post treatment medications and flush protocol medications will match the primary therapy administration requirements

☐ **No Premedications**

☐ Diphenhydramine _____mg ☐ PO ☐ IVP ☐ Post infusion every 4-6 hours, as needed for itching/site reaction

☐ Acetaminophen _____mg PO ☐ Post infusion every 4-6 hours, as needed for fever/headache

☐ Prednisone _____mg PO

☐ Hydration

SUPPLY DETAILED WRITTEN ORDER (DWO) CONTAINING: ANAPHYLAXIS, IV ACCESS, CATHETER MAINTENANCE, LAB WORK ORDERS, AND NURSING ORDERS.

By signing this form and utilizing our services, you are authorizing VitalCare of South Dallas, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies where allowed by law or contract.

Prescriber's Signature ______ *(Signature required. NO STAMPS)* ______ **AND** *Hand write: brand medically necessary, if needed* **Date**______________

Prescriber's Email______________________ **Prescriber's Fax** ______________________

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