IVIG TRANSPLANT REFERRAL FORM *(PAGE 1 OF 2)*

☐ Home Infusion ☐ Alternate Site of Care

NPI #: 1871219683
vitalcare of SOUTH DALLAS
TEL: 945-212-3707 **FAX:** 866-790-3580

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel_____ Cell_____ Email_____ Height _____ Weight _____ IBW _____ AjBW _____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

Practice Name _____ Primary Contact_____ Tel_____
Prescriber _____ NPI #_____ License #_____
Practice Address _____ Suite# _____ City _____ State _____ Zip _____
Email Address _____ Fax_____

**** Please fax a copy of front and back of insurance card ****

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____ ID#_____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10:
☐ **N18.6** End Stage Renal Disease
☐ **T86.10** Unspecified Complication of Kidney Transplant
☐ **T86.11** Kidney Transplant Rejection
☐ **T86.12** Kidney Transplant Failure
☐ **T86.13** Kidney Transplant Infection
☐ **T86.19** Other Complication of Kidney Transplant
☐ **T86.819** Unspecified Complications of Lung Transplant
☐ **T86.81** Other Complications of Lung Transplant
☐ **T86.810** Lung Transplant Rejection
☐ **T86.811** Lung Transplant Failure
☐ **T86.812** Lung Transplant Infection
☐ **Z94.2** Lung Transplant Status
☐ **Other ICD-10** _____ _____

BSA/M^2: _____ Blood Type: _____ Medical History: ☐ Diabetes ☐ Hypertension ☐ Other: _____
IGA Deficiency: ☐ Check box if patient requires low IGA product PRA Level: _____ (attach copy of results)
Dialysis Type: _____ Dialysis Schedule: _____
Previous Transplant History Dates: _____ Ship to Patient at ☐ Home ☐ Work ☐ Physician Office ☐ Other _____

PRESCRIPTION

PLEASE ATTACH CLEAR COPIES OF BOTH SIDES OF PATIENT'S INSURANCE CARDS

PHYSICIAN ORDERS - IVIG THERAPY ☐ NO IVIG REQUESTED

Is this the first dose? ☐ ☐ 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
☐ Infuse IVIG _____ GMS **OR** _____ mg/kg IV over _____ hours or as tolerated.
Dosage adjustments: ☐ Spilt all doses greater than _____ GMS
☐ Maximum total dose _____ GMS ☐ per dose **OR** ☐ per month
If not specified, will follow company policy for IVIG administration
Frequency: _____ QTY: _____ # of Refills: _____
☐ Pharmacy to select IVIG Product ☐ Specific Brand desired, please specify: _____

IVIG PRE-MED ORDERS Pre-Medicate: 30 minutes prior

☐ **No IVIG Pre-Meds**
☐ Prednisone _____ mg orally
☐ Hydrocortisone _____ mg IV push
☐ Diphenhydramine _____ mg orally
☐ Clonidine 0.1mg orally for BP > 160/95 and may repeat in one hour
☐ Acetaminophen _____ mg orally
☐ Other: _____

PHYSICIAN ORDERS - ACTEMRA (tocilizumab) ☐ NO ACTEMRA REQUESTED

Is this the first dose? ☐ ☐ Date of last infusion_____ Next dose due_____
Dose based on ☐ Actual Weight* ☐ IBW* *dose rounded to nearest vial size
☐ Infuse Actemra _____ mg **OR** ☐ _____ mg/kg in NS 100 ml IV over 60 minutes.
Frequency: _____ QTY: _____ # of Refills: _____
Actemra Pre-med Orders Pre-medicate: 30 minutes prior ☐ No Actemra Pre-meds
☐ Diphenhydramine _____ mg orally ☐ Acetaminophen _____ mg orally ☐ Hydrocortisone _____ mg IV push ☐ Other: _____

PHYSICIAN ORDERS - RITUXAN (rituximab) ☐ NO RITUXAN REQUESTED

Is this the first dose? ☐ ☐ Date of last infusion_____ Next dose due_____
☐ Infuse Rituxan _____ mg in _____ ml NS IV over 4 hours or as tolerated.
Frequency: _____ OR ☐ 5-7 days past 1st IV dose ☐ monthly QTY: _____ # of Refills: _____
Pre-medicate: 30 minutes prior
☐ Diphenhydramine _____ mg orally ☐ Acetaminophen _____ mg orally ☐ Other: _____

PHYSICIAN ORDERS - THYMOGLOBULIN (ANTI-THYMOCYTE GLOBULIN) ☐ NO ANTI-THYMOCYTE GLOBULIN

☐ Infuse Anti-Thymocyte Globulin _____ mg **OR** ☐ 2.5mg/kg* IVPB over _____ hours **OR** ☐ over 4 hours as tolerated.
☐ QTY: _____ # of Refills: _____ *Based on IBW and rounded to nearest 2.5 mg
Frequency: ☐ _____ **OR** ☐ Post-op day 1 is given in the hospital followed by home administration 1x daily on post-op days 3, 5, 7, and 9
(Anti-Thymocyte Globulin to be diluted in D5W or Normal Saline to a final concentration of 0.5mg/ml)
IV Access must be through a high flow vein. It is recommended to use a Midline/PICC or CVC.
Line should be placed in hospital prior to discharge.

ANTI-THYMOCYTE GLOBULIN (THYMOGLOBULIN) PRE-MED ORDERS

Pre-Medicate: 30 minutes prior
☐ Diphenhydramine _____ mg orally
☐ Hydrocortisone _____ mg IV push
Pre-Meds must be ordered for Anti-Thymocyte Globulin home administration
☐ Acetaminophen _____ mg orally ☐ Prednisone _____ mg orally
☐ Other: _____

COMPLETE PAGE 2 WITH CLINICAL INFORMATION

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Patient Name _____ DOB _____

PRESCRIPTION

PLEASE ATTACH CLEAR COPIES OF BOTH SIDES OF PATIENT'S INSURANCE CARDS

PHYSICIAN ORDERS - OTHER MEDICATIONS/THERAPIES

Medication/Drug Name: _____ Strength: _____ Dose: _____
Frequency: _____ Route of Administration: _____ Infusion Rate/Time: _____
QTY: _____ # of Refills: _____ ☐ Pharmacy to select Product ☐ Specific Brand desired, please specify: _____

PRE-MEDICATIONS Pre-medication 30 minutes prior.

☐ Diphenhydramine (Benadryl) _____ mg orally ☐ Acetaminophen (Tylenol) _____ mg
☐ Prednisone (Cortisone) _____ mg orally ☐ Other: _____

ANAPHYLAXIS /FLUSH/SUPPLY ORDERS

Equipment (pole, pump) / Supplies (needles, syringes, tubing, etc.) will be provided as per therapy and administration requirements and appropriate disposal of infusion materials.

IV Access: ☐ Peripheral ☐ Midline/PICC ☐ Port # of lumens: _____ Location: _____

Catheter Maintenance:

☐ Saline 0.9% Flush or D5W (determined by drug compatibility) 10ml syringe
☐ Heparin Flush 10 units/ml – 5ml syringe ☐ Heparin Flush 100 units/ml – 5ml syringe
Flush Orders: Flush with Saline 0.9% or D5W 5-10ml prior to and after each dose of medication and PRN to check catheter patency. For post lab work flush with 20ml saline 0.9%. Follow with Heparin 5 ml PRN for catheter maintenance (if required based on catheter type or if IV is left in place for subsequent infusion).

IV Access: ☐ Pheresis Catheter (when no other viable access is available).
Blue lumen used for administration of IVIG and/or Anti-Thymocyte Globulin. Red lumen used for lab work.

Flush Orders for Pheresis Catheter:

☐ Withdraw 6ml of Heparinized solution from Pheresis catheter prior to flush or lab draw, discard Heparinized solution.
☐ Saline 0.9% Flush 10ml or D5W (determined by IVIG compatibility) pre and post infusion, for post lab work flush with 20ml saline 0.9%
☐ Instill Heparin 1,000 units/ml _____ ml (equal to volume of lumen of catheter i.e.: 2ml)

Anaplylaxis Kit: ☐ Adult ☐ Pediatric (Diphenhydramine Injection 25mg/ml-2ml vial #2, Diphenhydramine 25mg capsules #2, Epinephrine 1mg/ml -1ml ampule #1) QTY: 2 Refills: _____

Anaphylaxis Orders: kit to be maintained in the home, monitored for expiration and replaced as needed.

1. Stop infusion
2. Call 911 and prescribing physician
3. Administer medications below as per protocol
4. Call BioMatrix

Medications:

Adults & children >66 lbs (30kg) ☐ Diphenhydramine 50mg orally, IM, or IV as needed for mild - severe allergic reaction
☐ Epinephrine 0.3mg/0.3ml IM or subcutaneously as needed for severe allergic reaction

Children ≤ 66lbs (30kg) ☐ Diphenhydramine 1.25mg/kg orally, IM, or IV as needed for mild - severe allergic reaction
☐ Epinephrine 0.15mg/0.15ml IM or subcutaneously as needed for severe allergic reaction

POST INFUSION ORDERS

☐ Acetaminophen _____ mg orally every 4-6 hours PRN fever/headache
☐ Diphenhydramine _____ mg orally every 4-6 hours PRN itching/rash/site reaction
☐ Other: Medication/Drug Name: _____ Strength: _____ Dose: _____
Frequency: _____ Route of Administration: _____

LAB WORK ORDERS ☐ No lab work

☐ CBC with diff ☐ ☐ ☐ BUN ☐ Other: _____ ☐ Frequency: _____
☐ PRA Level ☐ Frequency: _____ or ☐ Prior to 1st IVIG dose ☐ monthly
☐ DSA Level ☐ Frequency: _____ or ☐ drawn prior to 1st dose in the 6th month of treatment
☐ Lab Draw Flushing protocol: 5ml Saline pre blood draw , 20ml Saline post blood drawn, 5ml Heparin 100 unit/ml
☐ Additional Labs: _____ ☐ Frequency: _____
☐ Hold infusion(s) if: ☐ Hgb less than _____ ☐ Platelets less than _____ ☐ WBC less than _____

NURSING ORDERS

☐ Skilled nurse (SN) to provide care to complete therapy
☐ SN to provide education regarding: medication, disease state, signs and symptoms of complication/adverse drug reactions, infection control, safety, 24 hour on call availability, and emergency preparedness
☐ SN to place or access and maintain IV access according to INS standards and de-access or D/C when appropriate at completion of therapy. If port, PICC line or central line is occluded patient may be accessed via peripheral line
☐ IV Access: ☐ Peripheral ☐ Midline/PICC ☐ Port # of lumens _____ Location:_____
☐ Baseline Vital Signs: BP, HR, Temp prior to infusion, every 15 minutes x 1st hour and each subsequent hour until completion of therapy
☐ SN to administer drug(s) as per physician's orders stated above
☐ SN can infuse via gravity if needed
☐ Observe for response to therapy
☐ Hold infusion if: ☐ BP systolic above 180 mm Hg or ___mm Hg or ☐ BP diastolic above 105 mm Hg or ___mm Hg
☐ Nursing visit frequency: to cover number of days from frequency stated in physician orders above plus any lab draw days and PRN therapy related complications, catheter maintenance (dressing changes, access, etc.)

PLEASE INCLUDE THE FOLLOWING

☐ Lab results (attach copy of most recent results) ☐ Complete Patient History, reconciled medication list, and most recent clinical visit notes

COMMENTS _____

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_____