



Pharmacy Name:  
Address:  
City/State/Zip:

Phone:  
Fax:  
Email:

**Home Infusion  
Alternate Site of Care**

**Immunoglobulin Referral Form**

Patient Name	Home Phone		
Date of Birth	Mobile or Work Phone		
Patient Home Address	City	State	Zip
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		
Ordering Physician's Name	NPI		
Address	City	State	Zip
Phone	Fax		

**Please fax the following information:** History and Physical Pertinent Lab Work Front & Back copy(s) of patient's insurance card(s)

**Prescription**

<b>Intravenous Immunoglobulin</b> 0.4 gm/kg 1 gm/kg 2 gm/kg _____ grams <b>Infuse:</b> IV daily x ____ day(s); repeat every ____ week(s) x ____ cycles <b>Other:</b> _____	<b>Subcutaneous Immunoglobulin</b> Infuse _____ grams OR _____ mls using _____ sites _____ time(s) per week for _____ months.
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 IVIG patients only]: _____		Nurse to place PIV prior to therapy	
<b>Diagnosis</b>	<b>ICD-10</b>	<b>Diagnosis</b>	<b>ICD-10</b>
<b>Neuromuscular:</b>		<b>Immune Deficiency:</b>	
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	CVID w/ Predominant Immunoregulatory T-Cell Disorders	D83.1
Guillain-Barre Syndrome (GBS)	G61.0	Combined Immunodeficiency, Unspecified	D81.9
Multifocal Motor Neuropathy	G61.82	Common variable Immunodeficiency, Unspecified	D83.9
Myasthenia Gravis (MG)	G70.0	Hereditary Hypogammaglobulinemia	D80.0
Myasthenia Gravis with (Acute) Exacerbation	G70.01	Immunodeficiency with Increased IgM	D80.5
Autoimmune Encephalopathy	G04.81	Nonfamilial Hypogammaglobulinemia	D80.1
Inflammatory Neuropathies	G61.89	Other Combined Immunodeficiencies	D81.89
Relapsing Remitting Multiple Sclerosis (RRMS)	G35	Other Common Variable Immunodeficiencies	D83.9
Stiff Person Syndrome	G25.82	Pemphigoid	L12.0
<b>Other:</b>		Pemphigus	L10.9
Idiopathic Thrombocytopenic Purpura	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

<b>Please Draw:</b> CBC/diff    CMP    IgG w/ subclasses 1-4    Quant. Ig _____ Frequency: _____	<b>Anaphylaxis Protocol:</b> <b>PER Pharmacy Protocol</b> <b>PER Prescriber Protocol:</b> _____
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<b>Notes:</b>   	<b>Flushing Protocol:</b>  <b>PER Pharmacy Protocol</b> <b>PER Prescriber Protocol:</b> _____
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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.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.