Immunology IVIG Patient Referral Form

Return Signed Rx via fax to (800) 878-4160

Vital Rx
Specialized Pharmacy Services

Date	Fax #	# of Pages
Contact		Phone #

Patient's Name	D.O.B.	Height	Weight

Rx: Intravenous Route (*Dose will be rounded to nearest vial size*)

❒ Pharmacy Select ❒ Specify Brand:_____

_____ grams **OR** _____ grams per kg **OR**_____ mg per kg

Every _____ weeks

❒ Divide total dose over _____ days

❒ Refill for _____ months.

Rx: Subcutaneous Route (*Dose will be rounded to nearest vial size*)

❒ Pharmacy Select ❒ Specify Brand:_____

_____ grams **OR** _____ grams per kg **OR**_____ mg per kg

❒ Once weekly ❒ Every 2 weeks ❒ Other_____

❒ Refill for _____ months.

Diagnosis:

❒ D80.1 Hypogammaglobulinemia, unspecified
❒ D80.2 IgA Immunodeficiency
❒ D80.3 Other selective Ig deficiencies
❒ D80.4 IgM Immunodeficiency
❒ D80.5 Immunodeficiency with increased IgM
❒ D81.9 Combined immunity deficiency Agammaglobulinemia
❒ D82.0 Wiskott-Aldrich syndrome
❒ D83.0 Deficiency of cell-mediated immunity
❒ D83.1 Immunodeficiency with predominant T-cell defect, unspecified
❒ D83.8 or 83.9 Common variable immunodeficiency: acquired; primary
❒ Other:_____

IV Access Device: ❒ Peripheral ❒ Central ❒ Hydration: Infuse _____ml of NS or D5W.

Premedication Orders:

❒ Acetaminophen 650mg (325mg x 2) ❒ Oral / ❒ IV
❒ Diphenhydramine 25mg ❒ Orally / ❒ IV
❒ Solu Medrol® _____mg slow IVP
❒ Other

Additional Orders:

☑ Anaphylaxis Protocol Kit
❒ Epi-pen 0.3mg two (2) pack. Auto-injector if self infused.

If Applicable, flush intravenous access device per Comfort Infusion protocol:

Access	NS	Heparin 100u/ml
Peripheral	5-10 ml before/after use	3-5 ml after last NS
Midline, Central (Non-port) PICC	10 ml before/after use 10 ml before/after blood draw	5 ml after last NS
Implanted Port	10 ml before/after use 10-20 ml before/after blood draw	5 ml after last NS
Groshong PICC, Midline	10 ml before/after use 10-20 ml before/after blood draw	None

LAB ORDERS

❒ If needed, a Basic Metabolic Panel (Chem 7) to be drawn prior to first dose.

NURSING ORDERS

RN to infuse IVIG x _____ days every _____ week(s) and as needed. RN to provide initial education and PRN visits as needed.

If necessary Patient may have first dose administered in the home by a skilled nurse, unless instructed otherwise. Pharmacy to provide all equipment and medical supplies necessary to administer therapy as appropriate.

Prescriber Signature:_____ Date:_____ NPI # _____

Prescriber following patient if different from above:_____

Please fax the following information

❒ Immunoglobulin order - include dose, route of administration, frequency, duration, and any premedications OR use Rx order section above
❒ Patient demographics - include insurance information. We will obtain authorization, unless the insurance dictates otherwise.
❒ H & P OR progress note(s) describing diagnosis and clinical status
❒ Labs - BUN/Creatinine (preferred within last 90 days), Immunoglobulin Panel

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Phone: (866) 209-5540 | Fax: (800) 878-4160