



866 413-3156 toll free phone
 877 834-1231 toll free fax
 QUESTIONS? Please Contact Us!
 www.REPharmacy.com

Autoimmune Disorder Referral Form

Send your Rx to: _____ (optional)

Date Medication Needed: _____ Ship To: () Patient's Home () Prescriber's Office () Pick-Up (store location): _____ Injection training by pharmacy?

1) Patient & Insurance Information Please include copies of the FRONT and BACK of ALL insurance cards (Prescription and Medical) with this fax.

Patient Name: _____ Birth Date: _____ Sex: () Male () Female Height: _____ Weight: _____ () lbs. () kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Insurance Info: _____ Policy Number: _____

2) Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: _____ Fax: _____
 City, State, Zip: _____ Key Contact: _____ Phone: _____

3) Clinical Information Please FAX recent clinical notes, labs and/or tests, with the prescription, to expedite the prior authorization.

Other drugs used to treat patient's condition: _____
 First dose of IGIV: Yes No Prior IGIV products tried: _____
 Adverse reactions with previous IGIV treatments: _____
 ICD-10: _____ Acute Infective Polyneuritis (Guillain-Barre Syndrome) Inflammatory Polyneuropathy, Unspecified Polymyositis
 Pemphigus (Foliaceus / Vulgaris) Dermatomyositis Stiff-Person Syndrome
 Myasthenia Gravis with (Acute) Exacerbation Multiple Sclerosis (MS) Other: _____
 Myasthenia Gravis without (Acute) Exacerbation Multifocal Neuropathy (MMN) _____
 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) Pemphigoid _____

4) Prescription Information

Administer: SCIG IGIV **Product:** Pharmacist to determine Formulation: _____
Dose: Please select option(s) and provide complete information, (pharmacy to round to the nearest 5 gram vial).
 Loading Dose: _____ g/kg over _____ day(s), then
 _____ g daily for _____ day(s) every _____ week(s) x _____ cycle(s)
 _____ g/kg/day x _____ day(s) every _____ week(s) x _____ cycle(s) Other regimen: _____
Infusion Rate: (Please select one and provide complete information).
 Pharmacist to determine Start at _____ ml/hr, then increase by _____ ml/hr every _____ minutes to maximum rate _____ ml/hr
Access: Peripheral PICC Port Other: _____
IV Maintenance (Flushing): Dispense quantity sufficient.
 • Sodium Chloride 0.9% 10ml Prefilled Syringe: Flush IV access device with sodium chloride 3-10ml to maintain line patency.
 • Heparin 10 units/ml 5ml Prefilled Syringe: Flush peripheral IV access device with Heparin 10 units/ml 1-5 ml as needed to maintain line patency.
 • Heparin 100 units/ml 5ml Prefilled Syringe: Flush central IV access device with Heparin 100 units/ml 3-5 ml as needed to maintain line patency.
Adverse/Anaphylaxis Reaction: Anaphylaxis kit to be used in the event of anaphylactic reaction and will contain the following:
 • Diphenhydramine 25mg capsule #2 • Diphenhydramine 50mg/ml 1ml vial #1
 • Epinephrine Injection Auto-Injector 0.3mg (>30kg pt) or 0.15mg (<30kg pt) Two-Pack #1
 • Sodium Chloride 0.9% 10ml Prefilled Syringe #4 • Sodium Chloride 0.9% 500ml Bag #1
Pre-Treatment: Dispense quantity sufficient.
 Acetaminophen 325mg tablet: 1-2 tablets by mouth 15-30 minutes before each infusion Decline
 Diphenhydramine 25mg capsule: 1-2 capsules by mouth 15-30 minutes before each infusion Decline
 Other: _____
Ancillary Supplies: Dispense ancillary supplies and equipment needed to provide home infusion therapy.
Labs: Results will be faxed to physician's office. If no frequency noted, ordered labs to be done prior to initial infusion only. Labs will not be drawn on weekends or holidays. Not appropriate for STAT labs.
 Labs to be drawn: _____ Frequency of labs: _____

5) Patient Support Programs Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

 Patient Signature Date

6) Prescriber Signature Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written Date Substitution Permissible Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

#of Prescriptions