



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

Immune Globulin Referral Form

(Immune Deficiency)

Send your Rx to: _____ (optional)

Date Medication Needed: _____ Ship To: () Patient's Home () Prescriber's Office

1. Patient Information

Patient Name: _____ Birthdate: _____ Sex: () Male () Female Height: _____ Weight: _____ () lbs. () kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Alternate Caregiver Name: _____ Preferred Phone: _____
 E-mail: _____
 Emergency Contact Name: _____ Emergency Contact Phone: _____

2. Insurance Information Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

3. Prescriber Information

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

4. Diagnosis/Clinical Information Please FAX recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

Current history of: Renal Insufficiency Diabetes CHF Thromboembolic Event HTN Other: _____
 Has patient previously been on IG therapy? () Yes () No If yes: Date: _____ Brand: _____ Dose: _____
 Does patient have a latex allergy? () Yes () No

Please Provide the Following Documentation:
 Immune Deficiency: Detailed infection history, baseline IgG levels (including subclasses), immune response to vaccinations (including report) ITP: Platelet count: _____ Post-BMT or BCT: _____
 Allogeneic: _____ Autologous: _____

Pre-Protocols:
 If applicable, flush intravenous access device per RE Pharmacy protocol:

Venous	NS	Heparin 100 u/ml
Peripheral	1-3 ml before/after use	1-3 ml before/after NS
Midline, Central (Non-Port), PICC	3-5 ml before/after use, 5-10 ml after blood draw	3-5 ml before/after NS
Implanted Port	5-10 ml before/after use, 10-20 ml after blood draw	5 ml after last NS
Groshong PICC, Midline	5-10 ml before/after use, 10-20 ml after blood draw	none

5. Prescription Information

ICD-10 Codes and Diagnosis

C91.10 Chronic Lymphocytic Leukemia	D80.5 Hyper IgM	D81.1 Combined immunodeficiency, with Low B or T Cell Numbers
D80.1 Hypogammaglobulinemia	D83.9 Common Variable Immunodeficiency (CVID)	Z94.81 Bone Marrow replaced by Transplant (BMT)
D80.4 Selective IgM Deficiency	D83.8 Other Deficiency of Humoral Immunity	B20 HIV
D80.3 Other Selective Immunoglobulin Deficiency	D82.0 Wiskott-Aldrich Syndrome	Other ICD-10 (ICD-10 code and description)
D80.0 Bruton's X-Linked Agammaglobulinemia	D80.7 Transient hypogammaglobulinemia of infancy	
	D81.9 Combined immunodeficiency, unspecified	

Prescription Information: IVIG: _____ grams/kilogram daily for _____ day(s) **Nursing:** Administration at home by RN required: () Yes () No
 OR IVIG: _____ grams/kilogram daily given over _____ non-consecutive day(s) In home teach by RN: () Yes () No
 OR Other: _____ Other RN services requested: _____
 Repeat course every _____ week(s) for a total of _____ course(s).
 Dose will be rounded to nearest vial size.

Route of Delivery: IV Peripheral Central Subcutaneous Injection
 Other: _____

Method of Delivery:
 Ambulatory Pump (RE Pharmacy Suggested Protocol) Pole Mount Pump
 Subcutaneous Pump (Freedom 60) Other: _____

Premedication Orders / Other Orders:
 ACETAMINOPHEN 650 MG (325mg X 2) orally PRE-IVIG DIPHENHYDRAMINE 25 MG orally PRE-IVIG
 Anaphylactic/Epi-Pen 0.3mg 2-Pak Auto-Injector Other: _____

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/NT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____