MedicoRx Specialty & HOME INFUSION PHARMACY

IVIG - Transplant REFERRAL FORM

Phone: 818-390-9696 Toll-free: 855-265-7850 ● Fax: 818-804-3492 Toll-free fax: 855-450-6717 ● info@MedicoRX.com

Patient information		Prescriber information	
Name:	**DOB:**	**Prescriber's Name:**	
Address: **City, State, Zip**		**NPI#**	
		DEA#	**License#**
Phone #	**Alt#**	**Address** **City, State, Zip**	
SSN:			
Height:	**Wt:**	**Phone #**	**Fax #**
Allergies:			
Emergency Contact/ Phone #		**Contact Person:**	

Clinical Consideration

Diagnosis (ICD 10) :

- □ Z94.0 Transplant, Kidney
- □ D89.89 Autoimmune disease, not elsewhere classified
- □ T86.10 Complications of transplant organ, Kidney
- □ N18.6 End Stage Renal Disease
- □ B34.3 Polyoma viremia
- □ **Other (specify) :** _______________________________

If Applicable, flush access device per MedicoRx protocol		
Access	**NS**	**Heparin 100 U/Ml**
Peripheral	1-3 ml before/after use	1-3 ml after last NS
Midline - PICC Central (Non-Port)	3-5 ml before/after use 5-10 ml after blood draw	3-5 ml after last 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

Prescription Information

IV Access Device : □ **Peripheral** □ **Central**

□ **Hydration :** Infuse 500 ml of NS .. Start at 100 ml/hr, 30 minutes before the IVIG starts, hen run concurrently with IVIG infusion.

IVIG Dose by Physician : ____________________ __ Dose by Pharmacist : ________________________

Initial Loading Dose IVIG : _____________________ G/Kg (ABW) IV Daily for _________________Days

Maintenance Dose IVIG : ______________________ G/Kg (ABW) IV once every ________weeks/month

Duration : ___________________________________

Pre-Medications (15-30 minutes before infusion)

1. Nurse to instruct patient to drink enough fluid (2-4 cups/day) prior to IVIG infusion,
   Nursing to assess patient's hydration status and comorbidities.
   Check with prescribing physician if patient is volume restricted.
2. Take 2 tablets 325 mg Acetaminophen by mouth 30 minutes prior to each infusion as MD directed.
3. Take 1-2 capsules 25 mg Diphenhydramine by mouth 30 minutes to prior each infusion or Diphenhydramine 25-50 mg slow IV push over 2-5 minutes.
4. IV Steroids: **Dexamethasone**_____ **SoluMedrol**_____ **Solu-Cortef**_____ INSTRUCTIONS: __________________________
5. IV Hydration: NS__________ Other_________ ml: _______ over: _______hours

Anaphylaxis Kit Included: □ **Yes** □ **No**

Other Medications: PRN for infusion reaction per pharmacy protocol

□ Ibuprofen 400 mg PO every 8 hours PRN □ D5W or NS 250ml IV _____ □ Famotidine 20 mg IV _____

□ Dexamethasone 10 mg IV _____ □ Hydrocortisone 100 mg IV _____

LABS: □ Serum Creatinine □ BUN □ Urine Output **By MD** ________________ **By Home Nurse** ________________

By signing this form I authorize MedicoRX and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

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Prescriber's signature (no stamps) if brand required check this ☐ DAW___ **Date**