IMMUNE GLOBULIN PRESCRIPTION

Referral Form

MedicoRx Specialty & HOME INFUSION PHARMACY

Phone: (818) 390-9696 • Toll-Free: (855) 265-7850 • Fax: (855) 450-6717 • info@MedicoRx.com

Today's Date: _____ Needs By Date: _____ SHIP TO: ❑ Patient ❑ Office ❑ Other_____

PATIENT INFORMATION			PRESCRIBER INFORMATION	
PATIENT NAME			**PRESCRIBER NAME**	
ADDRESS			**NPI#**	
CITY, STATE, ZIP			**DEA#**	**LICENSE#**
MAIN PHONE#	**ALT.#**		**ADDRESS**	
SOCIAL SECURITY#			**CITY, STATE, ZIP**	
DATE OF BIRTH		**❑ MALE ❑ FEMALE**	**PHONE#**	**FAX#**
HEIGHT	**WEIGHT**	**❑ LBS ❑ KG**		
ALLERGIES			**CONTACT PERSON**	
OTHER MEDICATIONS				

DIAGNOSIS INFORMATION

❑ D80.1	Hypogammaglobulinemia	❑ G62.89	Multifocal Motor Neuropathy
❑ D80.0	Congenital Hypogammaglobulinemia	❑ G61.0	Guillain-Barré Syndrome
❑ D80.5	Immunodeficiency with Increased IgM	❑ G61.8	Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
❑ D83.9	Common Variable Immunodeficiency	❑ G70.0	Myasthenia Gravis
❑ D82.0	Wiskott-Aldrich Syndrome	❑ M33.90	Dermatomyositis
❑ D81.9	Combined Immunodeficiency	❑ M33.20	Polymyositis
❑ D69.3	Immune Thrombocytopenic Purpura		
❑ G25.82	Stiff Person Syndrome	❑ Other: _____	ICD-10 Code: _____
❑ G35	Multiple Sclerosis	❑ Secondary Diagnosis: _____	

PRESCRIPTION INFORMATION

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: for 1 year until further order or: _____
Administration per pharmacy protocol or: _____
Preferred Brand: _____

Pre-Medication: (15 to 30 minutes before infusion)

1. Home Health 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 325mg of Acetaminophen by mouth 30 minutes prior to each infusion as MD directed.
3. Take 1-2 capsules 25mg of Diphenhydramine by mouth 30 minutes prior to each infusion or Diphenhydramine 25-50mg slow IV push over 2-5 minutes.
4. IV Steroids: Dexamethasone: _____ SoluMedrol: _____ Solu-Cortef: _____ Instruction: _____
5. IV Hydration: NS: _____ Other: _____ ml: _____ over: _____ hours

Anaphylaxis Kit included: Yes _____/No _____

Other Medication: PRN for infusion reaction per pharmacy protocol
Ibuprophen 400mg PO every 8 hours PRN
D5W or NS250ml IV _____ Famotidine 20mg IV _____
Dexamethasone 10mg IV _____ Hydrocortisone 100mg IV _____
Others: _____

LAB: Serum creatinine, BUN & urine output. Other labs prior to infusion and each monthly cycle.
By MD _____ or By Home Nurse _____

Catheter flushes per Nursing SASH Protocol: Heparin 3-5ml (100/units/ml) Saline 5-10ml or D5W 5-10ml.
Supplies for method of Administration and Type of Line used per Pharmacy Protocol.

Home Health Nurse To Monitor:
Vital Signs and temperature pre-infusion, then every 15 minutes until maximum delivery rate is reached, then every hour x2, every 2 hours until completed and 15-30 minutes after completion of the infusion.

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

By signing this form and utilizing our services, you are authorizing MedicoRX and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

_____

Prescriber's Signature (no stamps) If Brand required check ❑ DAW_____ Initials_____ Date