ADDRESS: 12144 DAIRY ASHFORD RD. SUITE 100 SUGAR LAND, TX 77478

DELIVERIT
Infusion & Specialty

PHONE: (832) 939-8137
FAX: (832) 939-8128

IMMUNE GLOBULIN REFERRAL FORM

☐ **Infused at MDO.**

☐ **Infused at Home.** SET UP OF SKILLED NURSING VISITS REQUIRED.

COMPLETE PATIENT DEMOGRAPHIC INFORMATION IN SECTION BELOW

Or Attach Face Sheet from Patient Chart

Patient Name:		DOB:	Gender: ☐ Male ☐ Female	Weight:	☐ lbs ☐ kg
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip code :	

COMPLETE PATIENT INSURANCE INFORMATION IN THE SECTION BELOW

Or Attach Copies of Patient's Insurance Card

Primary insurance Carrier:	Name of the Insured:	Relationship:
Member ID #:	Group #:	Insurance Phone #:
Secondary Rx Carrier Name:	Rx ID #:	Rx Group #:

COMPLETE DRUG THERAPY INFORMATION IN THE SECTION BELOW

(Check any that apply)

IVIG Product Name: | Dose: | ☐ In Grams ☐ In Grams Per kg intravenously every: _____ Weeks.

☐ Divide total dose over _____ days. (Where clinically appropriate, round to the nearest vial size). | Number of Refills: _____

Access Device for IV: ☐ Peripheral Catheter ☐ Central | **Infusion** Method: ☐ Gravity ☐ Pump

Epinephrine: ☐ Patient weight ≥ 30 kg; inject 0.3 mg IM PRN for adverse reactions of IVIG. ☐ Patient weight 15-30 kg; inject 0.15 mg IM PRN for adverse reactions of IVIG.

Premedication:

☐ Diphenhydramine 25-50 mg PO, dispense #2 (25mg). ☐ Other _____

☐ Acetaminophen 650 mg PO, dispense #2 (325mg).

Current Medications/Therapies: _____

DIAGNOSIS ICD CODES

- ☐ Chronic inflammatory Demyelinating Polyneuropathy (CIDP) **G61.81**
- ☐ Hereditary Hypogammaglobulinemia **D80.0**
- ☐ Immunodeficiency with increased IgM **D80.5**
- ☐ Myasthenia Gravis without acute exacerbations **G70.00**
- ☐ Myasthenia Gravis with acute exacerbations **G70.01**
- ☐ Multiple Sclerosis **G35**
- ☐ Non-Familial Hypogammaglobulinemia **D80.1**
- ☐ Common Variable Immunodeficiency (CVID) **D83.9**
- ☐ Wiskott-Aldrich Syndrome **D82.0**
- ☐ Combined Immunodeficiency **D81.9**
- ☐ Multi-focal Motor Neuropathy **G61.82**
- ☐ Idiopathic Progressive Neuropathy **G60.3**
- ☐ Guillain-Barre Syndrome **G61.0**
- ☐ Other _____

COMPLETE PRESCRIBER INFORMATION IN SECTION BELOW

Prescriber Name:	NPI#:	Office#:	Fax#:
Address:	City:	State:	Zipcode:

SIGNATURE OF LICENSED PRESCRIBER (REQUIRED TO VALIDATE PRESCRIPTION)

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

Prescriber's Signature:

X_____

☐ DAW(Dispense as Written)

Date: _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.