IVIG Referral Form

Intravenous Immunoglobulin

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

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

Patient Insurance Information

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

Drug Therapy Information

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 Catheter	Infusion Method	☐ Gravity ☐ Pump

Epinephrine	☐ Patient weight **≥ 30 kg**; inject **0.3 mg IM PRN** for IVIG adverse effects. ☐ Patient weight **= 15-30 kg**; inject **0.15 mg IM PRN** for IVIG adverse effects.
Premedication	☐ **Diphenhydramine** 25-50 mg PO, dispense #2 (25 mg). ☐ **Acetaminophen** 650 mg PO, dispense #2 (325 mg). ☐ **Other:** _____
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**
- ☐ Multifocal Motor Neuropathy **G61.82**
- ☐ Idopathic Progressive Neuropathy **G60.3**
- ☐ Guillain-Barre Syndrome **G61.0**
- ☐ Other

Prescriber Insurance Information

Prescriber Name		NPI#		Office #		Fax #	
Address		City		State		Zip Code	

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

DAW (Dispense as written).

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.

Date

Prescriber's Signature

X _____