IVIG Referral Form

Intravenous Immunoglobulin

DELIVERIT™ Infusion & Specialty
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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_____