

Date Shipment Needed: \_\_\_\_\_ Ship To:  Patient  Prescriber  
 Nursing needed;  Training needed ► All the supplies including syringes and needles will be dispensed if needed.

## IVIG HOME INFUSION REFERRAL FORM

Phone: 866.506.2626 • Fax: 800.696.0607

PATIENT INFORMATION			
Patient Name:	DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:	
Address:	City:	State:	Zip:
Emergency Contact:	Phone:	<input type="checkbox"/> Please attach demographic information	
PRESCRIBER INFORMATION			
Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:
DIAGNOSIS INFORMATION / MEDICAL ASSEMENT			
<b>Primary Diagnosis, choose one:</b>			
<input type="checkbox"/> Guillian-Barre Syndrome	<input type="checkbox"/> Myasthenia Gravis		
<input type="checkbox"/> CIDP & Immune Neuropathies with Paraproteinemia	<input type="checkbox"/> Lambert-Eaton Myasthenic Syndrome		
<input type="checkbox"/> Immune Neuropathy other than CIDP without Paraproteinemia	<input type="checkbox"/> Polymyositis		
<input type="checkbox"/> CIDP	<input type="checkbox"/> Dermatomyositis		
<input type="checkbox"/> Vasculitic Neuropathy	<input type="checkbox"/> Diabetic Proximal Neuropathy		
<input type="checkbox"/> CVID	<input type="checkbox"/> Others _____		
<input type="checkbox"/> Multifocal Motor Neuropathy	<ul style="list-style-type: none"> <li>▪ Does patient already have a line? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type of line _____ IVIG to be infused via the existing line: <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>▪ First IVIG Infusion: <input type="checkbox"/> Yes, if yes, IgA level is more than 5 mg/dl: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Available → <input type="checkbox"/> Ig Quantitation: IgA, IgG, IgM (prior to 1<sup>st</sup> IVIG infusion)  <input type="checkbox"/> No, if no, brand/dose of IVIG: _____ Last infusion Date: _____</li> </ul>		
<small>Note: IVIG contains IgA and is contraindicated in IgA deficient patients with antibodies against IgA and history of hypersensitivity.</small>			
INSURANCE INFORMATION			
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)			
COPAY CARD ENROLLMENT			
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID: _____	
PRESCRIPTION INFORMATION			
<b>IVIG (IV Immunoglobulin) Order:</b> _____			
<small>*Will choose the IVIG brand if not specified</small>			
IVIG dose: _____ grams/kg = _____ grams (rounded to the nearest vial size) infuse intravenously			
Range: 0.2-2 grams/kg)			
<input type="checkbox"/> Repeat dose daily x _____ consecutive days total, repeat dose: <input type="checkbox"/> Monthly x _____ months <input type="checkbox"/> Other: _____ <input type="checkbox"/> Repeat dose weekly x _____ weeks total <input type="checkbox"/> Repeat dose monthly x _____ months total <input type="checkbox"/> Other: _____			
<b>Suggested Rate of Infusion:</b>			
<input type="checkbox"/> 30-150 mL/hr as tolerated by patient (increase rate gradually every 30 minutes by 20-30 mL/hr) <input type="checkbox"/> Other: _____			
<b>Pre-Medications: To be Administered 30 Minutes Prior to IVIG Infusion (QTY: Per Infusion)</b>			
<input type="checkbox"/> Diphenhydramine 25-50 mg PO, dispense #2 (25 mg) <input type="checkbox"/> Acetaminophen 650 mg PO, dispense #2 (325 mg) <input type="checkbox"/> Other: _____			
<b>Procedure for Anaphylaxis</b>			
<b>STOP</b> infusion and call MD and 911			
<input type="checkbox"/> Diphenhydramine 25-50 mg IVP every 4 hours prn (rate to not exceed 25 mg/min.) <input type="checkbox"/> Epinephrine (1:1000) 0.4 mg SQ prn anaphylaxis, may repeat every 20 minutes x 2 <input type="checkbox"/> Other: _____		QTY: _____	Refills: _____
		QTY: <u>3 amp</u>	Refills: _____
		QTY: _____	Refills: _____
<b>Supplies for Infusion</b>			
<input type="checkbox"/> NaCl 0.9% / D5W for flush: flush Line/Port with (3 – 5 mL for PIV and 5-10 ml for Central line/Port) per nursing agency protocol <small>(NaCl 0.9% or D5W will be used based on IVIG compatibility)</small>		QTY: <u>QS</u>	Refills: _____
<input type="checkbox"/> Heparin for flush (100 Units/ml) (if RN keeps PIV or if needed for Central Line), flush with 3 – 5 ml per nursing agency protocol		QTY: _____	Refills: _____
<input type="checkbox"/> Sterile water for reconstitution of powder to make the requested concentration (for Carimune NF)		QTY: _____	Refills: _____
<input type="checkbox"/> Other: _____		QTY: _____	Refills: _____

**Prescriber's Signature:** \_\_\_\_\_  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 AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

**IMPORTANT NOTICE:** This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.

# AcariaHealth™

**Specialty Pharmacy**

Phone: 800.511.5144 • Fax: 877.541.1503