vitalcare® INFUSION SERVICES

Pharmacy Name: Phone:
Address: Fax:
City/State/Zip: Email:

Immunoglobulin Referral Form

Patient Name	Home Phone		
Date of Birth	Mobile or Work Phone		
Patient Home Address	City	State	Zip
Primary Insurance Name			
Primary Insurance ID	Primary Insurance Group		
Insured Name	Insured DOB		
Secondary Insurance Name	Insurance ID	Insurance Group	
Secondary Insurance ID	Secondary Insurance Group		
Ordering Physician's Name	NPI		
Address	City	State	Zip
Phone	Fax		

Please fax the following information: ☐ History and Physical ☐ Pertinent Lab Work ☐ Front & Back copy(s) of patient's insurance card(s)

Prescription

☐ **Intravenous Immunoglobulin**

0.4 gm/kg 1 gm/kg 2 gm/kg _____ grams

Infuse: ☐ IV daily x ____ day(s); repeat every ____ week(s) x ____ cycles

☐ Other: _____

☐ **Subcutaneous Immunoglobulin**

Infuse _____ grams OR _____ mls using _____ sites

_____ time(s) per week for_____ months.

Hydration order: _____ mls NSiv to be infused prior/post IVIG.

☐ Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion
Diphenhydramine 25mg PO 30 mins prior to infusion

☐ Other Pre-medications: _____

Clinical Information

Patient Weight	Height	Allergies

☐ IV access [for IVIGg patients only]: _____ ☐ Nurse to place PIV prior to therapy

Diagnosis	ICD-10	Diagnosis	ICD-10
Neuromuscular:		**Immune Deficiency:**	
☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	☐ CVID w/ Predominant Immunoregulatory T-Cell Disorders	D83.1
☐ Guillain-Barre Syndrome (GBS)	G61.0	☐ Combined Immunodeficiency, Unspecified	D81.9
☐ Multifocal Motor Neuropathy	G61.82	☐ Common variable Immunodeficiency, Unspecified	D83.9
☐ Myasthenia Gravis (MG)	G70.0	☐ Hereditary Hypogammaglobulinemia	D80.0
☐ Myasthenia Gravis with (Acute) Exacerbation	G70.01	☐ Immunodeficiency with Increased IgM	D80.5
☐ Autoimmune Encephalopathy	G04.81	☐ Nonfamilial Hypogammaglobulinemia	D80.1
☐ Inflammatory Neuropathies	G61.89	☐ Other Combined Immunodeficiencies	D81.89
☐ Relapsing Remitting Multiple Sclerosis (RRMS)	G35	☐ Other Common Variable Immunodeficiencies	D83.9
☐ Stiff Person Syndrome	G25.82	☐ Pemphigoid	L12.0
Other:		☐ Pemphigus	L10.9
☐ Idiopathic Thrombocytopenic Purpura	D69.3	☐ SCID with Low or Normal B-Cell Numbers	D81.2
☐ Dermatopolymyositis	M33.90	☐ SCID with T- and B- Cell Numbers	D81.1
☐ Polymyositis	M33.20	☐ Selective Deficiency of IgG Subclasses	D80.3
		☐ Specific Antibody Deficiency	D80.6
		☐ Systemic Lupus Erythematosus (SLE)	M32.9

Please Draw:

☐ CBC/diff ☐ CMP ☐ IgG w/ subclasses 1-4 ☐ Quant. Ig
☐ _____ ☐ _____ Frequency: _____

Anaphylaxis Protocol:

○ **PER Pharmacy Protocol**

○ **PER Prescriber Protocol:** _____

Notes:

Flushing Protocol:

○ **PER Pharmacy Protocol**

○ **PER Prescriber Protocol:** _____

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED