

Address:

Phone: Fax:

INFUSION SERVICES City/State/Zip	:	Email:		
Immunoglobulin Referral Form				
Patient Name	Home Phone			
ate of Birth		Mobile or Work Phone		
Patient Home Address		City	State Zip	
		ony		
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		Subcutaneous Immunoglobulin		
0.4 gm/kg 1 gm/kg 2 gm/kg grams		Infuse grams OR mls using sites		
Infuse: IV daily x day(s); repeat every week(s) x cycles		time(s) per week for months.		
Other:				
Hydration order: mls NSiv to be infused prior/post IVIG.				
Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion Other Pre-medications:				
Diphenhydramine 25mg PO 30 mins prior to infusion				
Clinical Information				
Patient Weight Height Allergies				
IV access [for IVIGg patients only]: Nurse to place PIV prior to therapy				
Diagnosis ICD-10 Diagnosis		Diagnosis		ICD-10
Neuromuscular:		Immune Deficiency:		102 10
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)		CVID w/ Predominant Immunoregulator	y T-Cell Disorders	D83.1
Guillain-Barre Syndrome (GBS)		Combined Immunodeficiency, Unspecified		D81.9
Multifocal Motor Neuropathy		Common variable Immunodeficiency, Unspecified		D83.9
Myasthenia Gravis (MG) Myasthenia Gravis with (Acute) Exacerbation		Hereditary Hypogammaglobulinemia Immunodeficiency with Increased IgM		D80.0 D80.5
Autoimmune Encephalopathy		Nonfamilial Hypogammaglobulinemia		D80.3
Autoimmune Encephalopathy Inflammatory Neuropathies		Other Combined Immunodeficiencies		D81.89
Relapsing Remitting Multiple Sclerosis (RRMS)		Other Common Variable Immunodeficiencies		D83.9
Stiff Person Syndrome		Pemphigoid		L12.0
Other:		Pemphigus		L10.9
Idiopathic Thrombocytopenic Purpura		SCID with Low or Normal B-Cell Numbers		D81.2
Dermatopolymyositis M		SCID with T- and B- Cell Numbers		D81.1
Polymyositis	M33.20	Selective Deficiency of IgG Subclasses		D80.3
		Specific Antibody Deficiency Systemic Lupus Erythematosus (SLE)		D80.6 M32.9
		Systemic Lupus Li ythemotosus (SLL)		10132.9
Please Draw:	Anaphylaxis Protocol:			
CBC/diff CMP IgG w/ subclasses 1-4 Quant. Ig		PER Pharmacy Protocol		
Frequency:		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

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