

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

Immunoglobulin Referral Form					
Patient Name	Home Phone				
Date of Birth		Mobile or Work Phone			
Patient Home Address		City	State 2	Zip	
Primary Insurance Name					
Primary Insurance ID Primary Insurance Group					
Insured Name		Insured DOB			
Secondary Insurance Name	dary Insurance Name		Insurance ID Insurance Group		
Secondary Insurance ID		Secondary Insurance Group			
Ordering Physician's Name		NPI			
Address		City	State	Zip	
Phone		Fax	otate 1		
	Please fax the following information: History and Physical Pertinent Lab Work Front & Back copy(s) of patient's insurance card(s)				
Prescription 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 cy	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]:		I .		100.10	
Diagnosis Neuromuscular:	ICD-10	ICD-10 Diagnosis Immune Deficiency:		ICD-10	
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) G		CVID w/ Predominant Immunoregulatory T-Cell Disorders		D83.1	
Guillain-Barre Syndrome (GBS)		Combined Immunodeficiency, Unspecified		D81.9	
Multifocal Motor Neuropathy G61		Common variable Immunodeficiency, Unspecified		D83.9	
Myasthenia Gravis (MG) G70.0 Myasthenia Gravis with (Acute) Exacerbation G70.0		Hereditary Hypogammaglobulinemia Immunodeficiency with Increased IgM		D80.0 D80.5	
Autoimmune Encephalopathy G04.8		Nonfamilial Hypogammaglobulinemia		D80.1	
Inflammatory Neuropathies		Other Combined Immunodeficiencies		D81.89	
Relapsing Remitting Multiple Sclerosis (RRMS) G35 Other Common Variable Immunodeficiencies		encies	D83.9		
Stiff Person Syndrome G25.82 Pemphigoid		L12.0			
Other: Pemphigus Idiopathic Thrombocytopenic Purpura D69.3 SCID with Low or Normal B-Cell Numbers		L10.9 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: Anaphylaxis Protocol:					
CBC/diff CMP IgG w/ subclasses 1-4 Quant. Ig	PER Pharmacy Protocol				
Frequency:	_	PER Prescriber Protocol:		_	
Notes:		I			
Flushing Protocol:					
PER Pharmacy Protocol					
PER Prescriber Protocol:					
<u> </u>					
I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process Physician Signature:					
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. Date:					

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

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