Immune Globulin Autoimmune Disorder Referral Form

HPC SPECIALTY PHARMACY
IGAD_ 0109-1020

PATIENT INFORMATION

Patient Name: _____
Date of Birth: ____ /____ / ____ ☐ Male ☐ Female
SSN: ____ -____ - ____
Physical Address: _____
City: _____ State: _____ Zip: _____

Phone: (____) - ____ - _____ Emerg. Contact: _____
Email: _____ Emerg. Phone: (____) -____ -_____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: ____ /____ / ____
Allergies: Medications: *(Please attach additional pages if necessary)*

PRESCRIPTION BENEFITS INFORMATION *(Please attach front and back of insurance card)*

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____
Clinic/Hospital Affiliation: _____

Phone: (____) - ____ - _____
Fax: (____) - ____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

PREVIOUS THERAPY

Medication(s): _____

☐ IV ☐ SC Rate: _____

CLINICAL INFORMATION - PRIMARY DIAGNOSIS - ICD-10

☐ Acute Infective Polyneuritis (Guillain-Barre Syndrome)	ICD-10 _____	☐ Myasthenia Gravis without (Acute) Exacerbation	ICD-10 _____
☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	ICD-10 _____	☐ Pemphigus (Pemphigus Foliaceus, Pemphigus Vulgaris)	ICD-10 _____
☐ Dermatomyositis	ICD-10 _____	☐ Pemphigoid	ICD-10 _____
☐ Inflammatory Polyneuropathy, Unspecified	ICD-10 _____	☐ Polymyositis	ICD-10 _____
☐ Multiple Sclerosis (MS)	ICD-10 _____	☐ Stiff-Person Syndrome	ICD-10 _____
☐ Multifocal Neuropathy (MMN)	ICD-10 _____	☐ Other: _____	ICD-10 _____
☐ Myasthenia Gravis with (Acute) Exacerbation	ICD-10 _____		

PRESCRIPTION AND ORDERS

Administer: ☐ SCIG ☐ IVIG **Product:** ☐ Pharmacist to determine (or) ☐ Formulation: _____

Dose: *(please select option(s) and provide complete information, pharmacy to round the nearest 5 gram vial)*
☐ **Loading Dose:** _____ gm/kg OVER _____day(s), then ☐ **Maintenance Dose:** _____ gm/kg OVER _____day(s), EVERY _____ week(s) x_____ Refills
☐ **Other Regimen:** _____

Infusion Rate: *(please select one and provide complete information)*
☐ Pharmacist to determine
☐ Start at _____ mL/hr, then increase by _____ mL/hr every _____ minutes to maximum rate _____ mL/hr

Access: ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____

IV Maintenance (Flushing): __ Dispense Quantity Sufficient with 11 Refills - or - __ Decline
· Sodium Chloride 0.9% 10mL Prefilled Syringe: Flush IV access device with sodium chloride 3-10mL to maintain line patency.
· Heparin 10 units/mL 5mL Prefilled Syringe: Flush peripheral IV access device with Heparin 10 units/mL 1-5mL as needed to maintain line patency. **(pt<10kg)**
· Heparin 100 units/mL 5mL Prefilled Syringe: Flush peripheral IV access device with Heparin 100 units/mL 3-5mL as needed to maintain line patency. **(pt>10kg)**

Pre-Treatment: __ Dispense Quantity Sufficient with 11 Refills - or - __ Decline
Acetaminophen 325mg Tablet: 1-2 tablets by mouth 15-30 minutes before each infusion.
Diphenhydramine 25mg Capsule: 1-2 capsules by mouth 15-30 minutes before each infusion.
☐ Other: _____

Adverse/Anaphylactic Reactions: Anaphylaxis kit to be used in the event of anaphylatic reaction per HPC Protocol and will contain the following:
· Diphenhydramine 25mg Capsule #4 · Diphenhydramine 50mg/mL 1mL vial #2 · Sodium Chloride 0.9% 500mL Bag #1
· Epinephrine Injection Auto-Injector 0.3mg (>30kg pt) or 0.15mg (<30kg pt) Two-Pack #1 · Sodium Chloride 0.9% 10mL Prefilled Syringe #4

Ancillary Supplies: Dispense ancillary supplies and equipment *(including pump and pole)* needed to provide home infusion therapy.

Nursing Orders for Home Infusion *(IV Only)*

Frequency of vital signs monitoring:

a. If initial infusion or more than 8 weeks since last infusion:
- Prior to infusion
- q 15 minutes for the first hour
- q 30 minutes during the second hour
- q 1 hour for the remainder of the infusion

b. If subsequent infusion within 8 weeks:
- Prior to infusion
- q 15 minutes for the first hour
- q 1 hour for the remainder of the infusion

PRESCRIBER SIGNATURE *(Stamp signature not allowed, physician signature required)*

Product Selection Permitted	Dispense as Written	Date

PHONE: 1-800-757-9192
www.HPCSpecialtyPharmacy.com

PLEASE INCLUDE ALL MEDICAL RECORDS & LAB VALUES
PLEASE FAX TO 1-855-813-0583