Immune Globulin Primary Immune Deficiency Referral Form

HPC SPECIALTY PHARMACY

IGPID_0110-1020

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 Name: ________________________________

Address: ________________________________

City: ____________ State: _____ Zip: ______________

Contact: ________________________

Clinic/Hospital Affiliation: ___________________________

Phone: (____) - ____ - ________

Fax: (____) - ____ - ________

License #: ________________________

NPI #: ________________________

Medicaid Provider #: __________________

Medication(s): ________________

____

____

☐ IV ☐ SC Rate: ____________

CLINICAL INFORMATION - PRIMARY DIAGNOSIS - ICD-10

☐ Common Variable Immunodeficiency (CVID) ICD-10 __________

☐ Combined Immunity Deficiency & SCID ICD-10 __________

☐ Congenital Hypogammaglobulinemia ICD-10 __________

☐ Hypogammaglobulinemia ICD-10 __________

☐ Immunodeficiency with Increased Igm ICD-10 __________

☐ Selective IgM Immunodeficiency ICD-10 __________

☐ Selective Ig Immunodeficiency ICD-10 __________

☐ Other:________________________________ 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

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