Immune Globulin Primary Immune Deficiency Referral Form

Field Contact:

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

Diagnosis	ICD-10	Diagnosis	ICD-10
☐ Common Variable Immunodeficiency (CVID)	ICD-10 _________	☐ Immunodeficiency with Increased Igm	ICD-10 _________
☐ Combined Immunity Deficiency & SCID	ICD-10 _________	☐ Selective IgM Immunodeficiency	ICD-10 _________
☐ Congenital Hypogammaglobulinemia	ICD-10 _________	☐ Selective Ig Immunodeficiency	ICD-10 _________
☐ Hypogammaglobulinemia	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.hpcinfusion.com

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

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