

SCIG Infusion Referral Form



University Hospitals
Home Care Services

4510 Richmond Road
Warrensville Heights, OH 44128
Phone: 800-552-8442
Fax: 216-201-5127

Please complete each section of the referral form below and fax along with a copy (front and back) of all of the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information	Prescriber: _____ NPI: _____ Phone: _____ Fax: _____ Office Contact: _____ Address: _____ _____
Patient Information	Name: _____ DOB: _____ <input type="checkbox"/> M <input type="checkbox"/> F Address: _____ Phone: _____ 2 nd Phone: _____ MRN: _____ Primary Language: _____ Functional Limitations: _____
Clinical Information	Primary Diagnosis: _____ ICD-10 Code: _____ Secondary Diagnosis: _____ ICD-10 Code: _____ Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Height: _____ <input type="checkbox"/> in IgA deficiency: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, IgA level: _____ Allergies: _____ Latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No Prior treatments & reason for discontinuation: _____ Will this be the patient's first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, date of last dose: _____ Product given: _____ Dose: _____ Site of care: <input type="checkbox"/> Home Care Infusion Center <input type="checkbox"/> Home Infusion* <input type="checkbox"/> Home Care to determine site of care *Patient to be trained in the home by skilled nursing then transitioned to self-administration when clinically appropriate. Not available for Hyquvia or Cuvitru. Additional Notes: _____
Prescription Information	<div style="border: 1px solid black; padding: 5px;"> <input type="checkbox"/> Pharmacist to select IG product based on payer coverage and clinical appropriateness (select IG concentration desired below) <input type="checkbox"/> 10% product <input type="checkbox"/> 20% product </div> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <input type="checkbox"/> Specific IG Product required (select desired product below) 10% Products: <input type="checkbox"/> Gammagard Liquid <input type="checkbox"/> Gammaked <input type="checkbox"/> Gamunex-C <input type="checkbox"/> Hyquvia^ <input type="checkbox"/> Other: _____ 20% Products: <input type="checkbox"/> Cuvitru^ <input type="checkbox"/> Hizentra <input type="checkbox"/> Other: _____ ^Not available for home infusion </div> IG Dosing: _____ g/day for _____ day(s) every _____ weeks. Quantity (# of doses): _____ Rate of Administration: <input type="checkbox"/> Pharmacist to determine based on manufacturer guidelines <input type="checkbox"/> Custom: _____ PRN Medication(s): <input type="checkbox"/> Acetaminophen 325mg: 1-2 tablets PO Q4-6 hours prn (Do not exceed 4 doses/24 hours) Quantity: 120 Refills: PRN <input type="checkbox"/> Diphenhydramine 25mg: 1-2 tablets PO Q4-6 hours prn (Do not exceed 4 doses/24 hours) Quantity: 120 Refills: PRN <input type="checkbox"/> Other PRN medication(s): _____ Anaphylaxis Kit (to be provided to all home infusion patients): Patient Instructions: Keep on hand at all times during SCIG administration. For allergic reaction, STOP infusion, call 911 immediately, and administer the following medications as instructed by the emergency operator: <ul style="list-style-type: none"> • Diphenhydramine 25mg: 1-2 tablets PO (#2) • Epinephrine auto-injector IM (#2): 0.3mg for patients > 30kg; 0.15mg for patients < 30kg
Prescriber Signature	My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Home Care and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services, equipment, and supplies in conjunction with the therapy prescribed above. Signature: _____ Date: _____

Confidentiality statement: This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error, please notify the sender noted above and destroy all transmitted material.