IVIG 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:** _____ ☐ **M** ☐ **F**

Address: _____

Phone: _____ **2nd Phone:** _____ **MRN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis: ☐ Hereditary hypogammaglobinemia (D80.0) ☐ Combined immunodeficiencies (D81.89) ☐ Wiskott-Aldrich syndrome (D82.0)
☐ Common variable immunodeficiency (D83.8) ☐ Chronic Inflammatory Demyelinating Polyneuritis (CIDP) (G61.81)
☐ Acute Infective Polyneuritis (Guillain-Barre Syndrome) (G61.0) ☐ Inflammatory Polyneuropathy, unspecified (MMN) (G61.9)
☐ Other: _____ ICD-10 Code: _____

Weight:_____ ☐ lb ☐ kg **Height:**_____ ☐ in **IgA deficiency:** ☐ Yes ☐ No

Allergies: _____ **Latex allergy?** ☐ Yes ☐ No

Prior treatments & reason for discontinuation: _____

IV access: ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____

Will this be the patient's first dose? ☐ Yes ☐ No If no, date of last dose: _____ Product given: _____ Dose: _____

Referring provider's preferred site of care: ☐ Home Care Infusion Center ☐ Home Infusion ☐ Home Care to determine site of care
Site of care preference is subject to payer limitations, clinical appropriateness, and the availability of servicing providers.

Additional Notes:_____

_____

Prescription Information

IVIG Product: ☐ Pharmacist to determine based on availability and coverage

☐ Specific product required: _____

IG Dosing: _____ **g/day for** _____ **day(s) every** _____ **weeks.**

Quantity (# of doses): _____

Based on the clinical judgement of the pharmacist, doses may be rounded up or down by no more than 10% unless checked here: ☐

Rate of Administration: ☐ Pharmacist to determine based on manufacturer guidelines ☐ Custom: _____

Premedication(s):

☐ Acetaminophen 325-650mg PO 15-30 minutes prior to infusion ☐ Diphenhydramine 25-50mg PO 15-30 minutes prior to infusion

☐ Other premedication(s): _____

PRN Medication(s):

☐ Acetaminophen 325-650mg PO Q4 hours PRN ☐ Diphenhydramine 50mg IV x1 dose PRN ☐ Methylprednisolone 125mg IV x1 dose PRN

☐ Other PRN medication(s):_____

Laboratory orders (subject to availability): _____

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 and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____