QUICK RX SPECIALTY PHARMACY

tel: 800-496-6111

SUBCUTANEOUS IMMUNE GLOBULIN REFERRAL FORM

FAX: 800-540-1852

Today's Date

☐ **CURRENT PATIENT**
☐ **NEW PATIENT**

July 2016

Patient Name _____ SS# _____ DOB _____
Height _____ Weight _____ Address _____ Apt # _____
☐ Male ☐ Female City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed _____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

Insurance Carrier - Primary _____ Name of Insured _____
Relationship _____ ID # _____ Group # _____ Insurance Phone _____
Rx Carrier - Secondary _____ Rx ID # _____ Rx Group # _____ RX Phone _____

Prescriber's Name _____ Office Contact _____
Street Address _____ Suite# _____ City _____ State _____ Zip _____
Tel _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

Diagnosis ☐ ICD-10:_____ DX:_____ ☐ ICD-10:_____ DX:_____
☐ HTN ☐ Renal Dysfunction ☐ Thromboembolic event ☐ Other: _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PRESCRIPTION: _____(medication) _____ grams _____day(s) per week for _____ weeks via pump
TOTAL INFUSION VOLUME is: _____ Total # infusion sites: _____ duration of Infusion: _____min
DISPENSE a 4-week supply = _____mL with _____refills
Dose may be rounded to next vial size to minimize product wastage.

PRE-TREATMENT PROPHYLAXIS MEDICATION ORDERS
Administer 30-60 minutes prior to infusion:
☐ Acetaminophen 650 mg PO ☐ Diphenhydramine 25-50 mg PO ☐ Diphenhydramine 25-50 mg IV Push
☐ Hydrocortisone 100 mg/2 mL slow IV push ☐ Lidocaine/ Prilocaine Topically PRN ☐ Other_____

ANAPHYLAXIS ORDERS

ADULT (> 30 kg)
☐ Epinephrine 1:1000 (0.3 mg) Autoinjector
Administer IM or Sub-Q may repeat PRN
☐ Diphenhydramine: 50 mg IM/IV push, prn
☐ Other _____

PEDIATRIC (15-30 kg)
☐ Epinephrine 1:1000-JR (0.15 mg) Autoinjector
Administer IM or Sub-Q May repeat PRN
☐ Diphenhydramine: 1-2 mg/kg (up to 50 mg) IM/IV push, PRN
☐ Other: _____

SUBSTITUTIONS

PRODUCT SUBSTITUTION PERMITTED

_____
signature date

DISPENSE AS WRITTEN

_____
signature date

By signing this form and utilizing our services, you are authorizing Quick Rx Specialty and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

Provider please fax completed referral form to **Quick Rx Specialty Pharmacy** at **800-540-1852** Visit **www.QuickRxSpecialty.com** for online fillable forms.