

# IVIG NEUROLOGY 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 \_\_\_\_\_  
 Medical History:  Cardiac Disease  Diabetes  Renal Dysfunction  IgA Deficient  
 Allergies \_\_\_\_\_ Comorbidities \_\_\_\_\_  
 Current Medications (if necessary, please fax a complete list) \_\_\_\_\_

Diagnosis  G61.0 Guillain-Barre Syndrome  G70.80 Lambert-Eaton Syndrome, unspecified  
 G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)  M36.0 Dermatomyositis  
 G61.9 Inflammatory Polyneuropathy, unspecified  G25.82 Stiff-Person Syndrome  
 G70.01 Myasthenia Gravis with (Acute) Exacerbation  G35 Multiple Sclerosis (MS)  
 M33.20 Polymyositis, organ involvement unspecified  ICD-10: \_\_\_\_\_ DX: \_\_\_\_\_

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# \_\_\_\_\_

**PRESCRIPTION PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS**

Is this the first dose?  Yes  No If no:  
 List product \_\_\_\_\_  
 Date of last infusion \_\_\_\_\_  
 Next dose due \_\_\_\_\_

**ADMINISTER IVIG USING INFUSION PUMP:**  
 2 grams/kg over \_\_\_\_\_ days, as a loading dose, then \_\_\_\_\_ grams every \_\_\_\_\_ wk(s) for \_\_\_\_\_ cycle(s)  
 \_\_\_\_\_ gm/kg or \_\_\_\_\_ grams every \_\_\_\_\_ wk(s) for \_\_\_\_\_ cycle(s)  
 Other \_\_\_\_\_

**PRE-MEDICATIONS**  
 Diphenhydramine (Benadryl) 25-50 mg orally before infusion  
 Acetaminophen (Tylenol) 325-650 mg orally before infusion  
 Other \_\_\_\_\_

**ADVERSE/ANAPHYLACTIC REACTIONS: PER QUICKRX SPECIALTY PHARMACY PROTOCOL**  
 Adults or Children greater than 66 pounds or 30 kg:  
 • For mild reaction: give Diphenhydramine 50 mg orally, IM or IV and decrease the rate of infusion.  
 • For moderate reaction: stop infusion, give Diphenhydramine 50mg, orally, IM or IV and contact physician  
 • For Severe reaction w/breathing problem: stop infusion, call 911, give Epinephrine 0.3mg/0.3ml subcutaneously, Diphenhydramine 50 mg IV or IM. Begin NSS 500ml IV at a rate of 100-150ml/hr and contact physician.  
 Note: **Dosage adjustment necessary for children less than 30kg or 66 pounds:** Diphenhydramine 1.25mg/kg orally, IM or IV with a maximum of 50mg. If Epinephrine is needed 0.15mg/0.15ml 1:1000 subcutaneously

Nursing: Start PIV as required for administration and nurse to administer infusion in home.  
 Access:  Peripheral  PICC  Port  Other \_\_\_\_\_  
 Flushing: Quick Rx Specialty Protocol (Heparin, 0.9% NaCl, D5W)  
 Labs \_\_\_\_\_

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** \_\_\_\_\_

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Provider please fax completed referral form to **Quick Rx Specialty Pharmacy at 800-540-1852** Visit [www.QuickRxSpecialty.com](http://www.QuickRxSpecialty.com) for online fillable forms.