QuickRX SPECIALTY PHARMACY

INTRAVENOUS IMMUNE GLOBULIN REFERRAL FORM

Phone#: 347-691-3494 Fax#: 347-691-3496

Patient information

Patient Name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
1˚ Language: _____ Wt:_____ ❑ kg ❑ lbs Ht:_____ ❑ cm ❑ in
Address: _____
Apt/Suite: _____ City:_____ State: Zip:_____
Phone:_____ Alternate Phone:_____
Caregiver name: _____ Relation: _____
Local Pharmacy: _____ Phone: _____

Prescriber + Shipping Information

Prescriber Name:_____
NPI #: _____
Address: _____
Apt/Suite: _____ City:_____ State: Zip:_____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email address: _____
If shipping to presciber: ❑ 1st Fill ❑ Always ❑ Never

Insurance Information (Please fax a copy of front and back of the insurance cards)

1˚ Insurance Plan: _____ Plan ID # _____ Policy Holder: _____ Relation: _____
2˚ Insurance Plan: _____ Plan ID # _____ Policy Holder: _____ Relation: _____

Clinical Information (Please fax all pertinent clinical and lab information)

ICD-10/Diagnosis Code: _____
Date of Diagnosis: _____
IgA deficiency: ❑ Yes ❑ No IgA level _____ mg/dL Date:_____
IgG trough:_____mg/dL Date:_____ Diabetic: ❑ Yes ❑ No
Access: ❑ Peripheral Butterfly ❑ PICC ❑ Implant Port ❑ Broviac®/Hickman®
Has patient received immune globulin previously? ❑ Yes ❑ No
If yes, product information: _____
Date of last infusion: _____ Date of next infusion: _____
Comorbidities: _____
Allergies: ❑ NKDA ❑ Other: _____

Prescription

Immune Globulin Products	❑ Bivigam® 10%	❑ Carimune® NF	❑ Flebogamma® 5%	❑ Flebogamma® 10%
	❑ GammaKed® 10%	❑ Gammagard® Liquid10%	❑ Gammaplex® 5%	❑ Gammagard® S/D
	❑ Gamunex-C® 10%	❑ Octagam® 5%	❑ Octagam® 10%	❑ Privigen® 10%
	❑ IVIG (Pharmacy to determine)			
Therapy Regimen	Dose: _____ g/kg Total dose: _____ grams Daily for _____ days every _____ weeks # Doses: _____ Refills: _____ Administration Rate: ❑ Per manufacture guidelines, as tolerated ❑ _____			
Pre-Medications and Pre-Protocol	❑ Diphenhydramine _____mg 30 min before infusion ❑ PO ❑ IVP ❑ Acetaminophen _____mg 30 min before infusion PO ❑ Other: _____ ❑ Other: _____		❑ Hydration Infuse _____ mL _____ solution ❑ Prior to ❑ During ❑ Following ❑ Solu-Cortef® _____ mg slow IVP ❑ Solu-Medrol® _____ mg slow IVP ❑ Pre ❑ Halfway ❑ Upon completion	
Flushing Protocol	❑ Sodium Chloride 0.9% 5-10 mL pre and post medications		❑ Heparin _____Units/mL _____mL as needed	
Anaphylaxis Orders and Medications	Orders: 1. Stop infusion 2. Call 911 and prescribing physician 3. Administer medications below as per protocol			
	❑ Diphenhydramine Administer 25-50 mg slow IV/IM Dispense: 1 x 50 mg vial			
	❑ Epinephrine ❑ Administer 0.3 mg (1:1000) Sub-Q (≥ 30 Kg) ❑ Administer 0.15 mg (1:2000) Sub-Q (< 30 Kg) Dispense: 1 vial			
	❑ Sodium Chloride 0.9% Use as directed per the protocol Dispense: 1 x 500 mL Bag			
Ancillary Supplies	❑ As needed for proper administration and disposal of medication			
Skilled Nursing Visits	❑ As needed for IV access, administration and proper clinical monitoring			

Administration procedures to be followed per pharmacy protocol.

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Prescriber's Signature:_____ Date: _____

By signing this form and utilizing our services, you are authorizing QuickRX and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Please fax completed referral form to **QuickRx** at **347-691-3496**
Visit us at **quickrxspecialty.com** for online fillable forms.