briovaRx Infusion Services

Immunology Immunoglobulin Referral Form

Phone: **1-877-342-9352**
Fax: 1-888-594-4844

PATIENT INFORMATION

IG specialist Name:_____
Phone:_____

Patient ☐ see attached Gender: O Male O Female
Patient name:_____
DOB:_____ SSN:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Cell:_____
Emergency contact:_____
Phone:_____ Relationship:_____

Insurance ☐ Front and back of insurance card to follow

	Primary	Secondary
Insurance:		
Phone:		
Policy #:		
Group:		

Primary diagnosis:
☐ Combined immunodeficiency
☐ Common hypogammaglobulinemia
☐ Common variable immunodeficiency
☐ Immune thrombocyopenic purpura
☐ Immunodeficiency with increased IgM
☐ Wiskott-Aldrich syndrome
☐ Other:_____

Medical assessment
Height:_____ Weight:_____ O lbs O kg
Current medications? O Yes O No
If yes, list or attach:_____
Allergies:

PRESCRIPTION ORDERS

Immune Globulin:
☐ No preference
☐ Preferred product:_____

Initial:_____ gm/kg divided over_____ days
Ongoing:_____ gm/kg divided over_____ days
every_____ weeks for_____ cycles

Directions:
☐ Infuse IV ☐ Infuse SC
☑ Per manufacturer guidelines or as written below:
☑ May round to the nearest 5gm vial size

Quantity/Refills:
☐ 1-month supply; refill x 12 months unless otherwise noted
☐ Other:_____

Pre-medications 30 minutes before start of IG:
☐ Acetaminophen PO O 325 mg O 500 mg O 650 mg
☐ Diphenhydramine PO O 25 mg O 50 mg
☐ Hydration, solution: ____ Volume _____ mL
☐ Other:_____

Nursing and other orders:
☑ Administer IVIG or teach SCIG self-administration, via pump
☑ Ambulatory pump if required for infusion
☑ Initiate access device (insert peripheral IV, SC needles, access implanted port, or use existing PICC)
☑ Flush PIV with 5mL NS (for other orders, contact physician)
☐ Obtain labs (list):_____
Lab frequency: ☐ Once ☐ Monthly ☐ Other:_____

☑ Infusion reaction management and kit order

Mild	Slow infusion rate by 50% until symptoms resolve Diphenhydramine PO O 25 mg O 50 mg ☐ other:_____		
Moderate	Stop infusion, resume at 50% when symptoms resolve Diphenhydramine IV O 25 mg O 50 mg ☐ other:_____		
Severe (Anaphylaxis) *Call 911*	Stop infusion; initiate 0.9% NaCl 500 mL IV Administer epinephrine 1 mg/mL by weight (Wt):		
	Wt > 66 lbs (30 kg) = 0.3 mg/.3mL	Wt 33 - 66 lbs (15 - 30 kg) = 0.15 mg/0.15mL	Wt < 33 lbs (<15 kg) = 0.01 mg/kg
	Repeat epinephrine in 5-15 min if symptoms continue. Administer CPR if needed until EMS arrives.		

PHYSICIAN INFORMATION

Name:_____ Address:_____
Practice:_____ City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____ NPI:_____ Contact:_____

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Substitution permissible Signature:_____ Date:_____ *Dispense as written* Signature:_____