ivira infusions

IVIG Referral Form

Please fax completed referral form to ivira:
(302) 486-3400
Please contact office for questions:
(302) 356-0506

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	SECONDARY CONTACT #:
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE:

☐ PRIMARY IMMUNODEFICIENCY (PI) ________
☐ MYASTHENIA GRAVIS ________
☐ HYPOGAMMAGLOBULINEMIA ________
☐ IDIOPATHIC THROMBOCYTOPENIC PURPURA (ITP) ________
☐ MULTIFOCAL MOTOR NEUROPATHY (MMN) ________
☐ CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP) ________
☐ ________

PATIENT INFORMATION:

ALLERGIES: NKDA ☐	FIRST DOSE: ☐ Y ☐ N
	DATE OF LAST INFUSION:
	NEXT DOSE DUE BY:
HEIGHT: ____ Ft ____ In WEIGHT: ____ Lb or ____ Kg	LINE TYPE:
GENDER: ☐ F ☐ M	OTHER:

REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. PATIENT DEMOGRAPHICS ☐ 3. MOST RECENT LABS ☐ 4. H & P

PRIMARY MEDICATION ORDER:

Please include MEDICATION, DOSE, FREQUENCY, DURATION and any ADDITIONAL administration INSTRUCTIONS specific to the primary therapy.

BRAND:	DOSAGE:	FREQUENCY
☐ Gammagard 10%	☐ ____ gm per day	every ______ weeks
☐ Gammaked 10%	☐ ____ mg/kg over	one-time dose/treatment
☐ Gammaplex 10%	x ____ days	
☐ Gamunex 10%		
☐ Octagam 10%		
☐ Privigen 10%		
☐ Flebogamma DIF (10%)		
☐ Carimune _____%		

If weight-based dosing, dose on the patients:
☐ ACTUAL BODY WEIGHT ☐ IDEAL BODY WEIGHT

Round up to nearest vial size to prevent waste? YES NO

PRN & PREMEDICATIONS:

MEDICATIONS	30 minutes prior every infusion	PRN
Acetaminophen ____ 1000mg PO	☐	☐ PRN every ____ hours for mild infusion reaction.
Diphenhydramine ____ mg PO	☐	☐ PRN every ____ hours for mild infusion reaction.
Diphenhydramine ____ mg diluted in 10mL 0.9% NaCl slow IV push over 2-3 minutes.	☐	☐ PRN every ____ hours for mild infusion reaction.
Methylprednisolone ____ mg IV push over 5 minutes.	☐	
Normal Saline ____ mL over ____ min PRN or prior to every infusion.	☐	
Other:		

LINE USE/CARE ORDERS:

☐ START PIV/ACCESS CVC
☐ OTHER FLUSH ORDERS:

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

☐ ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS
☐ OTHER: (please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

PHYSICIAN SIGNATURE: DATE: