Advanced Infusion Care®

IVIg Home Infusion Referral Form

212 Northside Drive, Valdosta, GA 31602

Phone: 800.482.8466 | Fax: 844.259.0209

aicnewreferral@aiscaregroup.com | www.aiscaregroup.com

Important: To ensure timely processing, please include the following with completed referral form:

- ☐ Copy of Insurance Cards (front and back of card, including any secondary or tertiary plans)
- ☐ Demographic Information
- ☐ History and Physical With *ICD-10* Codes
- ☐ Relevant Diagnostic Procedures or Test Results
- ☐ Relevant Lab Results
- ☐ Recent Office Notes
- ☐ Recent CMP or BMP Lab Results

Note: Please fax the completed Referral Form to the number listed above. If submitting via email, please encrypt or send via some other secure means.

IVIg Home Infusion Referral Form

Fax completed form, insurance information, and clinical documentation to 844.259.0209.

If you have any questions or need assistance, please call 800.482.8466.

DEMOGRAPHIC INFORMATION

Patient name: _____ DOB: _____ Male ☐ Female ☐

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cellular phone: _____ Work phone: _____

Height: _____ in ☐ cm ☐ Weight: _____ kg ☐ lbs ☐

Known allergies? Yes ☐ No ☐ If yes, please list: _____

DIAGNOSIS

Autoimmune *ICD-10* diagnosis(es) codes: _____

Immunodeficiency *ICD-10* diagnosis(es) codes: _____

Other: _____

ORDERS

Initial: _____ gm/kg IV for _____ days every _____ week(s) administer via peripheral IV ☐ or CVAD ☐

Ongoing: _____ gm/kg IV for _____ days every _____ week(s) administer via peripheral IV ☐ or CVAD ☐

Other: _____

_____

Product choice: _____ Substitutions permitted unless box is checked ☐

Refill x _____ months, dispense 1-month supply.

Pharmacist to identify clinically appropriate Ig brand and infusion rates. Round dose to nearest whole 5 gm vial size.

Provide emergency meds as needed for severe allergic anaphylactic reaction and/or moderate allergic reaction.

Pre-medications to be given 30 minutes prior to each IVIg dose:

Diphenhydramine 25 mg IV ☐ or PO ☐ Acetaminophen 650 mg PO ☐ None ☐ Other: _____

Provide nursing or arrange patient/caregiver education as needed.

LABS

☐ IgG level and SCr in 6 months, then annually

☐ Other: _____

Prescriber: _____ Name of practice: _____

Office contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number: _____ Fax number: _____ NPI#: _____

MD signature: _____ **Date:** _____