Advanced Infusion Care®

IVIg Home Infusion Referral Form

212 Northside Drive, Valdosta, GA 31602

Phone: 800.482.8466 | Fax: 844.259.0209

www.aiscaregroup.com

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

- ☐ Insurance Information (copy of ALL insurance cards, front and back)
- ☐ Demographic Information
- ☐ H&P With recent Progress Notes (signed)
- ☐ Relevant Diagnostic Procedures or Test Results
- ☐ Relevant Lab Results
- ☐ Recent Office Notes
- ☐ Recent CMP or BMP Lab Results
- ☐ Medication List (current)

Note: Please fax the completed referral form to the number listed above.

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.

PATIENT DEMOGRAPHIC INFORMATION

Patient name: _____ DOB: _____ ☐ Male ☐ Female

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

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

Height: _____ Weight: _____ ☐ kg ☐ lbs

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

Emergency contact name: _____ Emergency contact phone: _____

DIAGNOSIS AND THERAPY HISTORY

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

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

Other: _____

Has the patient ever received immunoglobulin therapy?: ☐ Yes ☐ No

If yes, list therapy: _____

Last dose given: _____ Next dose due: _____

Concurrent meds: _____

PRESCRIPTION INFORMATION

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

MEDICATION	DOSE & DIRECTIONS	QUANTITY/REFILLS
IVIg	Initial: _____ gm/kg IV over _____ days every _____ week(s) administer intravenously Ongoing: _____ gm/kg IV over _____ days every _____ week(s) administer intravenously Other: _____ Product choice: _____	Quantity: ☐ 4-week supply ☐ 12-week supply Refills: ☐ 1 year ☐ Other: _____

PREMEDICATION: To be given 30 minutes prior to Ig dose — Check all that apply		
☐	Acetaminophen 325 mg: 2 po prior to each Ig dose	QS for each Ig dose + 1 yr refill
☐	Diphenhydramine 25 mg: 1 po prior to each Ig dose	QS for each Ig dose + 1 yr refill
☐	Hydration: 0.9% normal saline of _____ mL prior to Ig dose	QS for each Ig dose + 1 yr refill
☐	Other orders: _____ _____ _____	QS for each Ig dose + 1 yr refill

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

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PRESCRIPTION INFORMATION (CONT'D)

Complete below:

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS
☐ Epinephrine (nurse required)	☐ IM ☐ SQ	☐ Adult 1 mg/mL, 0.3 mL (>30 kg/70 lbs) ☐ Peds 1 mg/mL, 0.15 mL (<30 kg/33-70 lbs) May repeat in 5-15 minutes x 1 time as needed; PRN severe allergic reaction—Call 911
☐ Diphenhydramine 50 mg/mL vial	☐ IV ☐ IM	☐ Adult 25 mg (0.5 mL) >30 kg ☐ Peds 1.25 mg/kg <30 kg May repeat in 5-15 minutes x 1 time as needed (MAX dose is 50 mg combined—DO NOT exceed 50 mg); PRN severe allergic reaction—Call 911
☐ Solu-Cortef 100 mg/2 mL Act-O-Vial	IV	Adult >30 kg Activate vial. Administer over 2-3 minutes
☐ Normal saline	IV	☐ Adult >30 kg 500 mL KVO rate PRN anaphylaxis ☐ Peds <30 kg 250 mL KVO rate PRN anaphylaxis

CATHETER CARE

SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS
Catheter ☐ PIV ☐ Port ☐ PICC	IV	Catheter care/flush—Only on drug admin days—SASH or PRN to maintain IV access and patency PIV—5-10 mL NS pre- and post medication, IF REMAINS 2-3 mL of 10 units/mL heparin PORT/PICC—5-10 mL NS pre- and post medication, 3-5 mL of 100 units/mL heparin

LABS

☐ Ig level and SCr in 6 months, then annually ☐ Other: _____

NURSING

☐ A visit from a skilled nurse is needed to establish venous access, administer medication, and assess general status and response to therapy. Visit frequency based on prescribed orders.

If a nurse will be required for therapy administration, the home health nurse will call for additional orders per state regulations.
ALL fields must be completed to expedite prescription fulfillment.

Prescriber: _____ Name of practice: _____

Office contact: _____

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

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

PRESCRIBER SIGNATURE REQUIRED: Authorizing Above Nursing and Prescription Orders (Stamp Signature Not Allowed)

"Dispense As Written"/Brand Medically Necessary/Do Not Substitute/No Substitution/DAW/May Not Substitute

Prescriber's Signature

_____

Date

_____

OR May Substitute/Product Selection Permitted/Substitution Permissible

Prescriber's Signature

_____

Date

_____

CA, MA, NC, and PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**": _____