Advanced Infusion Care®

SQIg 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.

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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

DOSE & DIRECTIONS	QUANTITY/REFILLS
_____ Grams subcutaneously as directed once weekly; **or** _____ Grams subcutaneously as directed every other week; **or** Other: _____ Product choice: _____ **Pharmacist to identify clinically appropriate Ig brand and infusion rates. Round dose to nearest single-use vial size.**	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
	PRN Medications: To be given as needed	
☐	Lido/Prilo cream 2.5%: Apply to needle insertion site(s) prn as directed prior to infusion	#1 tube + 2 refills
☐	Other orders: _____	QS for each Ig dose + 1 yr refill
	Emergency Medications: As needed for severe allergic anaphylactic reaction and/or moderate allergic reaction.	
☐	Adult: Epinephrine Auto Injector 0.3 mg IM PRN severe reaction	For self-infusers 1 fill + 1 refill
☐	Peds: Epinephrine Auto Injector 0.15 mg IM PRN severe reaction	For self-infusers 1 fill + 1 refill

☐ 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

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NURSING

☐ A visit from a skilled nurse may be needed to train on proper utilization, administration, and to assess the general status of the patient. Visit frequency is 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**": _____