

Immunoglobulin Referral Form

Please attach copy of insurance card (front and back)

Last Name:	First Name:	DOB:	Practice:
Address:			Address:
City:	State:	Zip:	Sex: M F
Phone:	SSN #:	Prescriber Name:	
Insurance Plan			Prescriber NPI:
Insurance Plan:	Insurance Plan:	Nurse/Key Contact:	
Policy #:	Policy #:	Phone:	
Plan #:	Plan #:	Fax:	Email:

Diagnosis and Clinical Information

Please attach clinical/progress notes, labs, test supporting primary diagnosis

Allergies: _____

Weight: _____ Height: _____

IV access (for IVIg patients only): _____

Nurse to place PIV prior to therapy

Neuromuscular Diagnosis:	ICD-10
Chronic inflammatory demyelinating polyneuropathy (CIDP)	G61.81
Guillain-Barré syndrome (GBS)	G61.0
Multifocal motor neuropathy	G61.82
Myasthenia gravis (MG)	G70.0
Myasthenia gravis with (acute) exacerbation	G70.01
Autoimmune encephalopathy	G04.81
Inflammatory neuropathies	G61.89
Relapsing remitting multiple sclerosis (RRMS)	G35
Stiff person syndrome	G25.82
Other:	
Idiopathic thrombocytopenic purpura	D69.3
Dermatopolymyositis	M33.90
Polymyositis	M33.20

Immune Deficiency Diagnosis:	ICD-10
CVID with predominant immunoregulatory T-cell disorders	D83.1
Combined immunodeficiency, unspecified	D81.9
Common variable immunodeficiency, unspecified	D83.9
Hereditary hypogammaglobulinemia	D80.0
Immunodeficiency with increased IgM	D80.5
Nonfamilial hypogammaglobulinemia	D80.1
Other combined immunodeficiencies	D81.89
Other common variable immunodeficiencies	D83.9
Pemphigoid	L12.0
Pemphigus	L10.9
SCID with low or normal B-cell numbers	D81.2
SCID with T- and B-cell numbers	D81.1
Selective deficiency of IgG subclasses	D80.3
Specific antibody deficiency	D80.6
Systemic lupus erythematosus (SLE)	M32.9

Please draw:

CBC/diff CMP IgG with subclasses 1-4 Quant. Ig

Frequency: _____

Notes:

Anaphylaxis protocol:

PER pharmacy protocol

PER prescriber protocol: _____

Flushing protocol:

PER pharmacy protocol

PER prescriber protocol: _____

Prescription Information

Product:	Intravenous immunoglobulin	Subcutaneous immunoglobulin
Pharmacist to determine: _____	0.4 gm/kg 1gm/kg 2 gm/kg _____ grams	Infuse _____ grams OR _____ mls using _____ sites
Physician-branded: _____	Infuse: IV daily x _____ days(s); repeat every _____ week(s) _____ cycles	_____ time(s) per week for _____ months.
	Other: _____	
Hydration order: _____ mls NSiv to be infused prior/post IVIg		Other pre-medications: _____
Pre-medications: acetaminophen 650mg PO 30 mins prior to infusion diphenhydramine 25mg PO 30 mins prior to infusion		

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature:

Date:

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

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