Intravenous Immune Globulin Referral Form

MYLYFE SPECIALTY PHARMACY

31 Moody Rd. Enfield, CT 06082
1111 Elm St. Ste 12 West
Springfield, MA 01089
Phone & Fax: 844-469-5933

Patient Information

Patient Name:_____ DOB:_____
Sex: ☐ Female ☐ Male SSN: _____
Language:_____ Wt:_____ ☐kg ☐lbs Ht:_____ ☐cm ☐ in
Address:_____
Apt/Suite:_____ City:_____ State:_____ Zip:_____
Phone:_____ Alternate Phone:_____
Caregiver name:_____ Relation:_____
Local Pharmacy:_____ Phone: _____

Prescriber + Shipping Information

Prescriber Name:_____
NPI: _____
Address:_____
Apt/Suite:_____ City:_____ State:_____ Zip:_____
Contact:_____
Phone:_____ Alternate:_____
Fax:_____
Email address: _____
If shipping to prescriber: ☐ First Fill ☑ Always ☐ Never

Insurance Information (Please fax a copy of front and back of the insurance cards)

1˚ Insurance Plan:_____ Plan ID #_____ Policy Holder:_____ Relation: _____

Clinical Information (Please fax all clinical and lab information)

☐ D80.0 (Congenital Hypogammaglobulinemia) ☐ D80.1 (Nonfamilial hypogammaglobulinemia) ☐ D80.6 Selective Antibody Deficiency
☐ D81.9 (SCID, unspecified) ☐ D83.9 (CVID) ☐ G35 (Multiple Sclerosis) ☐ G61.0 (Guillane-Barré Syndrome) ☐ G61.81 (CIDP) ☐ G61.82 (MMN)
☐ G70.01 (MG **with** acute exacerbation) ☐ M33.20 (Polymyositis) ☐ M33.90 (Dermatomyositis)
☐ Other:_____ Diagnosis Date: _____
IgA deficiency: ☐ Yes ☐ No IgA level_____ mg/dl Date: _____
IgG trough:_____mg/dL Date:_____ Diabetes: ☐ yes ☐ no

Access: ☐ Peripheral ☐ PICC ☐ Implant Port ☐ Broviac®/Hickman®
Has patient received immune globulin previously? ☐ Yes ☐ No
If yes, product information: _____
Date of last infusion:_____ Date of next infusion: _____

Comorbidities:_____
Concomitant Medications: _____
Allergies: ☐ NKDA ☐ Other: _____

Prescription

Immune Globulin Products	☐ IVIG (pharmacist to determine appropriate product based on clinical risk assessment, insurance requirements and availability.) **OR** ☐ Enter Preferred Brand Name Here: _____	
Therapy Regimen	Dose:_____g/kg Total dose:_____grams Daily for_____days every_____weeks May adjust infusion schedule within +/- 7 days if nursing or patient need arises (with payer approval) Quantity to Dispense:_____doses Refills: _____ Administration Rate: ☐ Per manufacture guidelines, as tolerated ☐ _____ ☐ Check here if you would like Adjusted Body Weight used for dosing (if patient > 100kg)	
Pre-Medications and Pre-Protocol	☐ Diphenhydramine_____mg 30 min before infusion ☐ PO ☐ IVP ☐ Acetaminophen_____mg 30 min before infusion PO ☐ Other: _____ ☐ Other: _____	☐ Hydration Infuse_____mL_____solution ☐ Prior to ☐ Following ☐ Solu-Cortef®_____mg slow IVP ☐ Solu-Medrol®_____mg slow IVP ☐ Pre ☐ Halfway ☐ Upon completion
Flushing Protocol	☐ Sodium Chloride 0.9% 5-10 mL pre and post medications	☐ Heparin_____Units/mL_____mL as needed

The quantity and refills for pre-treatment and flushing protocol medications will match the immune globulin administration requirements.

Anaphylaxis Orders and Medications	Orders: 1. Stop infusion 2. Call 911 and prescribing physician 3. Administer medications below as per protocol		_____ Refills
	Diphenhydramine 50 mg/mL: ☐ Administer 12.5 mg/0.25 mL (weight <15 kg) by slow IV push or IM ☐ Administer 25 mg/0.5 mL (weight 15-30 kg) by slow IV push or ☐ IM Administer 50 mg/mL (weight >30 kg) by slow IV push or IM	Quantity: 1 x 50 mg vial	
	Epinephrine 1 mg/mL: ☐ Administer____mg (0.01 mg/kg or 0.01mL/kg) (weight <15 kg) ☐ IM Administer 0.15 mg/0.15 mL (weight 15-30 kg) IM ☐ Administer 0.3 mg/0.3mL (weight >30 kg) IM	Quantity: 2 vials	
	☐ Sodium Chloride 0.9% Use as directed per protocol	Quantity: 1 x 500 mL Bag	
Pump and Ancillary Supplies	☐ Pump and supplies as needed for administration and appropriate disposal of infusion materials.		
Skilled Nursing Orders and Plan of Treatment	☐ Nurse to place PIV or use PICC/PORT to infuse IVIG as directed. ☐ Assess and monitor vital signs and systems review with each visit ☐ Instruct on the following: Disease process, signs and symptoms, and complications; Medication therapy including action, purpose, side effects, storage of medication and supplies; Universal precautions, 911, 24 hour phone number, when to call RN/Physician		

Prescriber's Signature:_____ Date: _____

I authorize Mylyfe Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Mylyfe Pharmacy