IVIG Referral Form

Reset Form

accredo℠ a medco company

Referral Date: _____ ***Please fax front & back copy(s) of patient's insurance card(s) with referral***

Patient Information

Patient Name	DOB	Sex □ M □ F	Last 4 digits of SSN
Address		Phone #	
City / State / Zip		Employer	
Primary Insurance		Phone #	
Name of Insured		Relationship	
Last 4 digits of SSN	DOB	Employer	
Group #		Policy #	
Secondary Insurance		Phone #	
Name of Insured		Relationship	
Last 4 digits of SSN	DOB	Employer	
Group #		Policy #	

Medical Information

Primary Diagnosis: ICD-9 Code:

Weight: □ lbs. □ kg Height: □ in □ cm Diabetic: □ Yes □ No

Allergies:

Has patient received IVIG previously? □ Yes □ No If YES, please list product: _____

If NO, can first dose be given in home? □ Yes □ No Date of last infusion: _____

Baseline lab values (if available, fax copy to Accredo). Date of values: _____

BUN _____ SCr _____ IgA _____ Serum Viscosity _____ LFTs _____

Medication Orders

Immune Globulin Product: □ Do Not Substitute Refills: _____times (as allowed by state or payor requirements)

Administer _____ mg per kg (+ or - 10%) **OR** _____ gms IV every _____ days **OR** Other Regimen: _____

Administration Rate: Follow manufacturer guidelines **OR** Other: _____

Pre-medication: _____

□ EMLA®, ElaMax® 4%, Lidocaine 4% (topical cream to be applied topically to site for venous accessing prn)

Provide needles, syringes, VAD supplies & other ancillary supplies needed for infusion

Delivery Method: Gravity Vascular Access Device: □ Peripheral Catheter □ Other (describe/# of lumens): _____

Flush Orders: □ Normal Saline 1-50 mls pre or post infusion prn

□ D5W 1-50 mls pre or post infusion prn

□ Heparin 100 units per ml 1-5 ml post infusion prn □ Heparin 10 units per ml 1-5 ml post infusion prn

Adverse Reaction Medications to be maintained in the patient's home & administered as necessary:

Diphenhydramine 25-50 mg PO or IV prn allergic reaction

Epinephrine 1:1000 Subcut IM prn severe allergic reaction:

Adults: 0.02 mg per kg up to 0.5 mls Pediatrics greater than 10 lbs: 0.01 mg per kg up to 0.3 mls

Accredo Nursing Services Requested □ Yes □ No

□ Skilled nursing visit to establish venous access, patient education related to therapy & disease state, administer medication as prescribed, assess general status, and response to therapy. Visit frequency based on prescribed dosage orders.

Additional Requirements:

Physician Information

Physician Name	License #	NPI#	UPIN #
Date Time	Name & Title of person faxing this form		
Address			
Office Contact	Phone	Fax	

**This form is a generic referral form that could be utilized for any IVIG provider and is meant to provide the pertinent information needed to process an IVIG referral.*

***If Nursing Services 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 Signature _____ _____ Date_____

Dispense as Written **Substitution Allowed**

(Physician attests this is his/her legal signature. NO STAMPS) By signing, I certify that the above therapy is medically necessary.

If shipped to physician's office, physician accepts on behalf of patient for administration in office

For questions or if you wish to submit a referral, please contact Accredo at

Phone: 866 820-IVIG or 866 820-4844 **Fax: 866 233-7151**

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