# IVIG REFERRAL FORM

FLEXCARE INFUSION CENTERS

## PATIENT DEMOGRAPHICS

| | |
|---|---|
| Patient Name: | Patient's Phone Number: |
| Date of Birth: | Address: |
| Allergies: See List ☐ NKDA ☐ | City, State, Zip: |
| Weight:_____lbs or _____kg | Patient's Email: |

## REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Dems • Most Recent Labs • Med List • Current IG Levels

## PRIMARY DIAGNOSIS

☐ D80.0 Hereditary hypogammaglobulinemia
☐ D80.1 Nonfamilial hypogammaglobulinemia
☐ D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses
☐ D83.9 Common variable immunodeficiency, unspecified
☐ D89.89 Oth dsrd involving the immune mechanism, NEC
☐ G35.A Relapsing-remitting multiple sclerosis
☐ G61.81 Chronic inflammatory demyelinating polyneuritis
☐ G61.82 Multifocal motor neuropathy
☐ G70.00 Myasthenia Gravis without (acute) exacerbation
☐ G70.01 Myasthenia gravis with (acute) exacerbation
☐ G72.49 Oth inflammatory and immune myopathies, NEC
☐ L13.8 Other specified bullous disorders
☐ M33.00 Juvenile dermatomyositis, organ involvement unspecified
☐ M33.10 Other dermatomyositis, organ involvement unspecified
☐ M33.13 Other dermatomyositis without myopathy
☐ M33.20 Polymyositis, organ involvement unspecified
☐ M33.22 Polymyositis with myopathy
☐ M33.90 Dermatopolymyositis, unsp, organ involvement unspecified
☐ M33.91 Dermatopolymyositis, unsp with respiratory involvement
☐ Other:_____

## LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

## PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for IVIG
☐ Provider Prescribed: _____

## PRIMARY MEDICATION ORDER

**No Brand Preference:**
☐ No brand preference - Immune Globulin Solution 5%
☐ No brand preference - Immune Globulin Solution 10%

**If Brand Preference:**
☐ Gamunex-C 10%
☐ Gammagard Liquid 10%
☐ Octagam 5%
☐ Octagam 10%
☐ Privigen 10%
☐ Bivigam 10%
☐ Panzyga 10%
☐ Other _____

**Dosing:**
☐ _____GRAMS/kg or _____grams divided equally over _____ days every _____ weeks
☐ _____mg/kg or_____miligrams divided equally over _____ days every _____ weeks

☐ Other: _____

*Dose will be rounded to the nearest 5g vial size. To prohibit dose rounding, check here ☐

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

## LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

## ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

## PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

| | |
|---|---|
| Provider Name: | Office Contact: |
| Address: | Phone: |
| City, State, Zip: | ☐ Fax: |
| NPI **AND** License: | ☐ Email: |

Provider Signature _____ Date _____

**FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals**

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