Toll Free Fax (866)728-4810
Phone (323)201-4488

University Specialty Pharmacy
IVIG Referral Form

PATIENT INFORMATION

First Name	Last Name	Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis

	Code	Description		Code	Description
☐	287.3	ITP Primary	☐	358.0	Myasthenia gravis without (acute) exacerbation
☐	279.00	Hypogammaglobulinemia, Unspecified	☐	358.01	Myasthenia gravis with (acute) exacerbation
☐	340.0	Multiple Sclerosis	☐	358.1	Easton-Lambert Syndrome (Myasthenic)
☐	333.91	Stiff Person Syndrome	☐	446.1	Kawasaki Syndrome
☐	356.0-356.4	Hereditary and idiopathic peripheral nueropathy	☐	694.4	Pemphigus (Pemphigus Foliaceus, Pemphigus Vulgaris)
☐	356.9	Peripheral Neuropathy, Unspecified	☐	694.5	Pemphigoid (Bullous Pemphigoid)
☐	357.0	Acute infective polyneuritis (Guillain-Barrè Syndrome)	☐	710.3	Dermatomyositis
☐	357.2	Diabetic Polyneuropathy	☐	710.4	Polymyositis
☐	357.8	CIDP (Chronic Inflammatory Demyelinating Polyneurpathy)	☐	Other	IDC-9 Code ________________________
☐	357.82	Critical illness Polyneuropathy (Acute motor neuropathy)			Description ________________________________

Other Medical History: ____ Allergies: ____

Height: __________ Weight: __________ as of date: _____/_____/_____ Therapy Start Date: _____/_____/_____ Duration: _____/_____/_____

HISTORY OF: ☐ Renal Dysfunction: Explain: ______________________________ ☐ HTN: Explain: ______________________________

☐ Thromboembolic event: Explain: ______________________________ ☐ OTHER: Explain: ______________________________

☞ DELIVER TO: ☐ Patient's Home ☐ MD ☐ AIS ☜

PRESCRIPTION

IVIG: (5% 6% 7.5% 9% 10%) Solution – **Please (circle one)**

Dose:

Option A – 400 mg/kg/day x 5 days (2 gm/kg) every 4-6 weeks for ________ months

Option B – _______ grams daily for _______ days every 4-6 weeks for ________ months

Infusion Rate:

Option A – ______cc/hr for the first hour. ______cc/hr for the second hour. ______cc/hr thereafter.

Option B – start at ______cc/hr, then increase by ______cc/hr every ______ minutes to maximum rate: ______cc/hr

Repeat / Maintenance Treatment: In __________ or every _________weeks/months. Repeat x _______.

I.V. Access: ☐ Peripheral ☐ Central

Monitor: Vital signs prior to infusion. Blood pressure and pulse every 30 minutes until stable infusion rate then every hour.

Watch for: Signs of fluid overload, cardiovascular symptoms, allergic reaction, skin rash, and fever, moderate to severe headache.

Call/Page MD: For adverse events, stop the infusion. Can restart the infusion at the same or lower rate pending physician's approval or if symptoms subside

Pre-Treatment:
- ☐ Tylenol 1 gm p.o. 15-30 minutes before the infusion starts
- ☐ Benadryl 25 mg p.o. 15-30 minutes before the infusion starts
- ☐ Aspirin ____ 500 mg or ____ 325 mg p.o. 15-30 minutes before the infusion starts
- ☐ Other: ____

Other Medications: Patient to take his/her own medications, as prescribed

Blood Test:
- ☐ CBC; Metabolic panel (Chem-7) prior to first infusion
- ☐ Immunofixation; Immunoglobulins quantitation (Before 1st / _____ Treatment). Fax Results.
- ☐ Other: ____. Fax Results.

Physician Signature: ____ **Date** __________________

PHYSICIAN INFORMATION

MD: ____ License: ________________________DEA: ________________________

Hospital/Clinic: ____ Phone: ________________________ Fax: ________________________

Address: ____

Office Contact: ________________________________NPI#: ________________________ Medicaid #: ________________________