

IVIG REFERRAL FORM

Central Fax: 800-504-0870

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 Dets • Most Recent Labs (BMP) • Med List • Creatine Level • Current IG Levels

PRIMARY DIAGNOSIS

☐ C91.0 Acute lymphoblastic leukemia [ALL]	☐ D83.9 Common variable immunodeficiency, unspecified	☐ M33.20 Polymyositis, organ involvement unspecified
☐ D80.1 Nonfamilial hypogammaglobulinemia	☐ G35 Multiple sclerosis	☐ M33.22 Polymyositis with myopathy
☐ D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses	☐ G61.81 Chronic inflammatory demyelinating polyneuropathy	☐ M33.90 Dermatopolymyositis, unspecified, organ involvement unspecified
☐ D80.9 Immunodeficiency with predominantly antibody defects, unspecified	☐ G61.82 Multifocal motor neuropathy	☐ M72.6 Necrotizing fasciitis
☐ D83.0 Com variable immunodeficiency w/ predominant abnlt of B-cell nums & function	☐ G70.00 Myasthenia gravis without (acute) exacerbation	☐ T86.10 Unspecified complication of kidney transplant
☐ D83.1 Com variable immunodeficiency w/ predominant immunoreg T-cell disorders	☐ G72.49 Oth inflammatory and immune myopathies, NEC	☐ T86.11 Kidney transplant rejection
	☐ J84.9 Interstitial pulmonary disease, unspecified	☐ Z94.0 Kidney transplant status
	☐ L10.0 Pemphigus vulgaris	☐ Other: _____
	☐ M33.13 Other dermatomyositis without myopathy	

PRE- MEDICATIONS: (15-20 mins before infusion) ** selected pre-medications will be given per Suite Life protocol unless otherwise indicated**

☒ Tylenol 650mg	☒ Solu-Medrol 40mg IVP	☐ Diphenhydramine 25mg PO or IVP
☒ Cetrizine 10mg PO	☐ Solu-Medrol 125mg IVP	☐ Diphenhydramine 50mg PO or IVP
☐ Pepcid 20mg PO or IVP		
☐ Other: _____		

PRIMARY MEDICATION ORDER: If necessary, Suite Life will round dose up/down according to payor guidelines

No Brand Preference:	If Brand Preference:	
☐ No brand preference - Immune Globulin Solution 5%	☐ Gamunex-C 10%	☐ Octagam 5%
☐ No brand preference - Immune Globulin Solution 10%	☐ Gammagard Liquid 10%	☐ Octagam 10%
		☐ Bivigam 10%
		☐ Panzyga 10%
		☐ Other: _____

Dosing:

☐ _____ GRAMS/kg or _____ GRAMS IV divided equally over _____ days every _____ weeks

☐ _____ milligrams/kg or _____ milligrams IV divided equally over _____ days every _____ weeks

☐ Other: _____

Infusion time per mg 1kg 1 hr

*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 Suite Life Health's protocol (See suitelifehealth.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 Suite Life Health's protocol (See suitelifehealth.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

Rev: 8/25