PRESCRIPTION ORDER FORM

# IVIG REFERRAL FORM

Suite Life
Infusing health and wellness into your life.
215 Pleasant Street, 5th Floor, Fall River, MA 02721
Phone: (508) 567-5666 | Fax: (508) 567-5614

## 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

☐ C91.0 Acute lymphoblastic leukemia [ALL]
☐ D80.1 Nonfamilial hypogammaglobulinemia
☐ D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses
☐ D80.9 Immunodeficiency with predominantly antibody defects, unspecified
☐ D83.0 Com variable immunodeficiency w/ predominant abnlt of B-cell nums & function
☐ D83.1 Com variable immunodefiency w/ predominant immunoreg T-cell disorders
☐ D83.9 Common variable immunodeficiency, unspecified
☐ G35 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
☐ J84.9 Interstitial pulmonary disease, unspecified
☐ L10.0 Pemphigus vulgaris
☐ M33.13 Other dermatomyositis without myopathy
☐ M33.20 Polymyositis, organ involvement unspecified
☐ M33.22 Polymyositis with myopathy
☐ M33.90 Dermatopolymyositis, unspecified, organ involvement unspecified
☐ M72.6 Necrotizing fasciitis
☐ T86.10 Unspecified complication of kidney transplant
☐ T86.11 Kidney transplant rejection
☐ Z94.0 Kidney transplant status
☐ Other: _____

## LAB ORDERS: PLEASE INCLUDE FREQUENCY

☐ CBC w/ diff & ANC: _____ ☐ LFT's at month 2 then every 3 months after ☐ Other: _____

## PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

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

## 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%
☐ 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

* Infusion time per mg/kg 1 hr

☐ 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 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