HOME INFUSION GROUP

IVIg / SCIg REFERRAL FORM

FAX: 718-676-9111
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PATIENT INFORMATION

Patient Name: ______________________________
Home Address: ______________________________
City, State, Zip: ______________________________
Home Phone: ______________________________
Cell Phone: ______________________________
SS: ______________________________
Date of Birth: ______________ Gender: ☐ Male ☐ Female
Contact Person & #: ______________________________

PRESCRIBER INFORMATION

Prescriber Name: ______________________________
Home Address: ______________________________
City, State, Zip: ______________________________
Phone: ______________________________
Fax: ______________________________
DEA: ______________ License #: ______________
NPI #: ______________________________

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card)

Primary Insurance: ______________ ID#: ______________ Group: ______________
Secondary Insurance: ______________ ID#: ______________ Group: ______________
Prescription Card: ______________ ID#: ______________ BIN: ______________ PCN: ______________ Group: ______________

DIAGNOSIS

☐ Primary Immune Deficiency – specify Code: _______
☐ D83.9 Common Variable Immunodeficiency (CVID)
☐ D50.1 Hypogammaglobulinemia
☐ G35 Multiple Sclerosis
☐ G60.9 Multifocal Motor Neuropathy
☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ G70.01 Myasthenia Gravis
☐ D69.3 Idiopathic Thrombocytopenic Purpura (ITP)
☐ Other: ______________________________

PATIENT EVALUATION

Has patient previously received IVIG ☐Yes ☐No
Patient Current Weight: _______ Kg/ Lbs.
Height: ____Inches/cm
Allergies: ______________________________

PRESCRIPTION INFORMATION

Medication	Directions (Route / Frequency / Length of Infusion)	Quantity (Grams)	Refills
Intravenous Immune Globulin			
☐ Gammaked 10%			
☐ Gamunex-C			
☐ Octagam 10%			
☐ Privigen 10%			
☐ Gammagard 10% Liquid			
☐ Flebogamma 5% DIF			
☐ Gammaplex 5%			
☐ Other: ______________			
Subcutaneous Immune Globulin			
☐ Hizentra 20%			
☐ Gammagard 10% Liquid			
☐ Gamunex-C			

Other Medications

PREMEDICATE WITH: ☐ **Diphenhydramine (Benadryl)** ______ mg ☐ PO ☐ Inj. ☐ **APAP(Tylenol)** ______ mg ☐ PO ☐ Other: ___________
PRN for Anaphylactic Reaction: ☐ **Hydrocortisone 100mg** IV Push ☐ **Epinephrine 0.3mg IM** **Sodium Chloride 0.9%**: ☐ 250 ml ☐ 500 ml

☐ Sodium Chloride 0.9% **Flush** ☐3 ml ☐5 ml ☐10 ml ☐20 ml ☐30 ml ☐ Flush IV line before and after infusion
☐ Heparin Flush **10** units/ml ☐3 ml ☐5 ml ☐ Heparin Flush **100** units/ml ☐3 ml ☐ 5 ml ☐ Flush IV line after infusion

NURSING: Requires Placement ☐ PIV ☐ Midline IV Line for administration and nurse to administer infusion in home

Current IV Access: ☐PIV ☐PICC ☐Midline ☐PORT ☐OTHER ________ ___# **Number of Lumens** Delivery Method: ☐Gravity ☐Infusion Pump
Therapy Start Date: ______________ Length of Therapy: ______________ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No

By signing this form and utilizing our services, you are authorizing Home Infusion Group, Inc. and it's employees to serve as your authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature: ______________________________ (required)   **Date:** ______________ (required)

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