ETOWN VITAL CARE
INFUSION PHARMACY

**Locations:** Louisville, Elizabethtown, Radcliff, Smiths Grove, Bowling Green, Russellville.

**Fax: 270-506-2466, Phone: 270-506-2463**

# Immune Deficiency Referral Form

| | | | |
|---|---|---|---|
| Patient Name | Home Phone | | |
| Date of Birth | Mobile or Work Phone | | |
| Patient Home Address | City | State | Zip |
| Primary Insurance Name | | | |
| Primary Insurance ID | Primary Insurance Group | | |
| Insured Name | Insured DOB | | |
| Secondary Insurance Name | Insurance ID | Insurance Group | |
| Secondary Insurance ID | Secondary Insurance Group | | |
| Ordering Physician's Name | NPI | | |
| Address | City | State | Zip |
| Phone | Fax | | |

**Please fax the following information:** History and Physical Pertinent Lab Work Front & Back copy(s) of patient's insurance card(s)

## Prescription

**Intravenous Immunoglobulin**

0.4 gm/kg 1 gm/kg 2 gm/kg _____ grams

Infuse: IV daily x ____ day(s); repeat every ____ week(s) x ____ cycles

Other: _____

**Subcutaneous Immunoglobulin**

Infuse _____ grams OR _____ mls using _____ sites

_____ time(s) per week for_____ months.

Hydration order: _____ mls NSiv to be infused prior/post IVIG.

Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion
Diphenhydramine 25mg PO 30 mins prior to infusion

Other Pre-medications: _____

## Clinical Information

| | | |
|---|---|---|
| Patient Weight | Height | Allergies |

IV access [for IVIGg patients only]: _____ Nurse to place PIV prior to therapy

| Diagnosis | ICD-10 | Diagnosis | ICD-10 |
|---|---|---|---|
| **Neuromuscular:** | | **Immune Deficiency:** | |
| Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) | G61.81 | CVID w/ Predominant Immunoregulatory T-Cell Disorders | D83.1 |
| Guillain-Barre Syndrome (GBS) | G61.0 | Combined Immunodeficiency, Unspecified | D81.9 |
| Multifocal Motor Neuropathy | G61.82 | Common variable Immunodeficiency, Unspecified | D83.9 |
| Myasthenia Gravis (MG) | G70.0 | Hereditary Hypogammaglobulinemia | D80.0 |
| Myasthenia Gravis with (Acute) Exacerbation | G70.01 | Immunodeficiency with Increased IgM | D80.5 |
| Autoimmune Encephalopathy | G04.81 | Nonfamilial Hypogammaglobulinemia | D80.1 |
| Inflammatory Neuropathies | G61.89 | Other Combined Immunodeficiencies | D81.89 |
| Relapsing Remitting Multiple Sclerosis (RRMS) | G35 | Other Common Variable Immunodeficiencies | D83.9 |
| Stiff Person Syndrome | G25.82 | Pemphigoid | L12.0 |
| **Other:** | | Pemphigus | L10.9 |
| Idiopathic Thrombocytopenic Purpura | D69.3 | SCID with Low or Normal B-Cell Numbers | D81.2 |
| Dermatopolymyositis | M33.90 | SCID with T- and B- Cell Numbers | D81.1 |
| Polymyositis | M33.20 | Selective Deficiency of IgG Subclasses | D80.3 |
| | | Specific Antibody Deficiency | D80.6 |
| | | Systemic Lupus Erythematosus (SLE) | M32.9 |

**Please Draw:**

CBC/diff _____ CMP _____ IgG w/ subclasses 1-4 Quant. Ig

Frequency: _____

**Anaphylaxis Protocol:**

**PER Pharmacy Protocol**

**PER Prescriber Protocol:** _____

**Notes:**

**Flushing Protocol:**

**PER Pharmacy Protocol**

**PER Prescriber Protocol:** _____

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____

Date: _____

**PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED**