IVIG - NEUROLOGY/IMMUNOLOGY REFERRAL FORM *(PAGE 1 OF 2)*

NPI #: 1730504002
BIOMATRIX **TEL:** 877-567-8087 **FAX:** 877-567-8089

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel_____ Cell_____ Email_____ Height _____ Weight _____ IBW _____ AjBW _____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

Practice Name Abington Neurological Associates Primary Contact_____ Tel 215-957-9250
Prescriber _____ NPI #_____ License #_____
Practice Address 1151 Old York Road Suite# 200 City Abington State PA Zip 19001
Email Address _____ Fax 215-957-9254

**** Please fax a copy of front and back of insurance card ****

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____ ID#_____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10:

- **D80.0** Hereditary Hypogammaglobulinemia
- **D80.1** Nonfamilial Hypogammaglobulinema
- **D80.5** Immune Deficiency with Increased IGm
- **D81.0** Severe Combined Immunodefic. w/ Reticular Dysgenesis
- **D81.1** Immunodeficiency with Low T-and B-Cell Numbers
- **D81.2** Severe Combined Immunodeficiency with Low/Normal T- and B-Cell Numbers
- **D81.6** Major Histocompatability Complex Class 1 Deficiency
- **D81.7** Major Histocompatability Complex Class 2 Deficiency
- **D81.89** Other Combined Immunodeficiences
- **D81.9** Combined Immunodeficiency, unspecified
- **D82.0** Wiskott Aldrich Syndrome
- **D83.0** CVID with Predom Abnlt of B-Cell Numbers & Function
- **D83.2** CVID with Autoantibodies to B- or T-Cells
- **D83.8** Other Common Variable Immunodeficiences
- **D83.9** Common Variable Immunodeficiency, unspecified
- **G25.82** Stiff-Person Syndrome
- **G35** Multiple Sclerosis
- **G61.0** Gullian-Barre Syndrome
- **G61.81** CIDP
- **G61.881** Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- **G61.89** Other Inflammatory Polyneuropathies
- **G62.89** Other Specified Polyneuropathies
- **G64** Other Disorders of Peripheral Nervous System
- **G69.49** Other Primary Thrombocytopenia
- **G70.01** Myasthenia Gravis with (Acute) Exacerbation
- **G70.80** Lambert-Eaton syndrome, unspecified
- **G671.82** Multifocal Motor Neuropathy
- **M33.20** Polymyositis, organ involvement, unspecified
- **M36.0** Dermatomyositis
- **P61.0** Transient Neonatal Thrombocytopenia
- **Other ICD-10** _____ Description_____

Medical History: ☐ Diabetes ☐ Hypertension ☐ Other: _____
IGA Deficiency: ☐ Check box if patient requires low IGA product Recent IGA level _____

PRESCRIPTION

PLEASE ATTACH CLEAR COPIES OF BOTH SIDES OF PATIENT'S INSURANCE CARDS

Is this the first dose? ☐ Yes ☐ No
If no: List product_____ Date of last infusion_____ Next dose due_____
Dose based on ☐ Actual Body Weight* ☐ Adjusted Body Weight* ☐ Ideal Body Weight* *rounded to nearest 5 grams
Ship to Patient at ☐ Home ☐ Work ☐ Physician Office ☐ Other: _____

PHYSICIAN ORDERS

☐ IVIG Therapy: Infuse IVIG _____ GMS or _____ gm/kg IV over _____ hours or as tolerated.
If not specified, will follow company policy for IVIG administration.
Frequency: _____ QTY: _____ # of Refills: _____
☐ Pharmacy to select IVIG Product ☐ Specific Brand desired, please specify: _____
☐ Other Therapy: Infuse _____ Dose_____ Frequency _____
Route of Administration: _____ Infusion Rate: _____ QTY:_____ # of Refills: _____
☐ Pharmacy to select IVIG Product ☐ Specific Brand desired, please specify: _____

PRE-MEDICATIONS

The quantity and refills for pre/post treatment medications and flush protocol medications will match the primary therapy administration requirements

☐ **No IVIG Pre-Meds**
☐ Diphenhydramine ____ mg orally
☐ Pre-medicate 30 minutes prior to infusion ☐ Post infusion every 4-6 hours, as needed for itching/site reaction
☐ Acetaminophen ____ mg orally
☐ Pre-medicate 30 minutes prior to infusion ☐ Post infusion every 4-6 hours, as needed for fever/headache
☐ Prednisone ____ mg orally
☐ Pre-medicate 30 minutes prior to infusion
☐ Other _____

COMPLETE PAGE 2 WITH CLINICAL INFORMATION

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Patient Name _____ DOB _____

PRESCRIPTION

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ANAPHYLAXIS /FLUSH/SUPPLY ORDERS

Equipment (pole, pump) / Supplies (needles, syringes, tubing, etc.) will be provided as per therapy and administration requirements and appropriate disposal of infusion materials.

IV Access: ☐ Peripheral ☐ Midline/PICC ☐ Port # of lumens: _____ Location: _____

Catheter Maintenance:

☐ Saline 0.9% Flush or D5W (determined by IVIG compatibility) 10ml syringe
☐ Heparin Flush 10 units/ml – 5ml syringe ☐ Heparin Flush 100 units/ml – 5ml syringe

Flush Orders: Flush with Saline 0.9% or D5W 5-10ml prior to and after each dose of medication, with lab draws and PRN to check catheter patency. Follow with Heparin 1-3 ml
Per SASH protocol and PRN for catheter maintenance if IV is left in place for subsequent infusion.

Anaplylaxis Kit: ☐ Adult ☐ Pediatric (Diphenhydramine Injection 25mg/ml-2ml vial #2, Diphenhydramine 25mg capsules #2, Epinephrine 1mg/ml -1ml ampule #1) QTY: 2 Refills: _____

Anaphylaxis Orders: kit to be maintained in the home, monitored for expiration and replaced as needed.

1. Stop infusion
2. Call 911 and prescribing physician
3. Administer medications below as per protocol
4. Call BioMatrix

Medications:

Adults & children >66 lbs (30kg)

☐ Diphenhydramine 50mg orally, IM, or IV as needed for mild - severe allergic reaction
☐ Epinephrine 0.3mg/0.3ml IM or subcutaneously as needed for severe allergic reaction

Children ≤ 66lbs (30kg)

☐ Diphenhydramine 1.25mg/kg orally, IM, or IV as needed for mild - severe allergic reaction
☐ Epinephrine 0.15mg/0.15ml IM or subcutaneously as needed for severe allergic reaction

LAB WORK ORDERS

☐ No lab work
☐ Lab orders: _____
☐ Frequency of lab work: _____
☐ Lab Draw Flushing protocol: 5ml Saline pre blood draw , 20ml Saline post blood drawn, 5ml Heparin 100 unit/ml

NURSING ORDERS

☐ Skilled nurse (SN) to provide care to complete therapy
☐ SN to provide education regarding: medication, disease state, signs and symptoms of complication/adverse drug reactions, infection control, safety, 24 hour on call availability, and emergency preparedness
☐ SN to place or access and maintain IV access according to INS standards and de-access or D/C when appropriate at completion of therapy. If port, PICC line or central line is occluded patient may be accessed via peripheral line
☐ IV Access _____ # of lumens _____ Location:_____
☐ Baseline Vital Signs: BP, HR, Temp prior to infusion, every 15 minutes x 1st hour and each subsequent hour until completion of therapy
☐ SN to administer drug(s) as per physician's orders stated above
☐ SN can infuse via gravity if needed
☐ Observe for response to therapy
☐ Hold infusion if: ☐ BP systolic above 180 mm Hg or _____mm Hg or ☐ BP diastolic above 105 mm Hg or _____mm Hg
☐ Nursing visit frequency: to cover number of days from frequency stated in physician orders above plus any lab draw days and PRN therapy related complications, catheter maintenance (dressing changes, access, etc.)

PLEASE INCLUDE THE FOLLOWING

☐ Lab results (attach copy of most recent results)
☐ Complete Patient History, reconciled medication list, and most recent clinical visit notes

COMMENTS _____

_____

_____

_____

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies where allowed by law or contract.

Prescriber's Signature _____ *(Signature required. NO STAMPS)* *Hand write: brand medically necessary, if needed* **Date**_____

Prescriber's Email_____