

SUBCUTANEOUS IMMUNE GLOBULIN REFERRAL FORM**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 _____ BSA _____
Ship to Patient at Home Work OR Patient will pick up at Physician Office Local Pharmacy Phone _____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

Practice Name _____ Primary Contact _____ Tel _____
Prescriber _____ NPI # _____
Practice Address _____ Suite# _____ City _____ State _____ Zip _____
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# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Code

<input type="checkbox"/> D80.0 Hereditary Hypogammaglobulinemia	<input type="checkbox"/> D81.89 Other Combined Immunodeficiencies
<input type="checkbox"/> D80.5 Immunodeficiency with Increased immunoglobulin M (IgM)	<input type="checkbox"/> D81.9 Combined Immunodeficiency, Unspecified
<input type="checkbox"/> D81.0 Severe Combined Immunodeficiency with Reticular Dysgenesis	<input type="checkbox"/> D82.0 Wiskott-Aldrich Syndrome
<input type="checkbox"/> D81.1 Immunodeficiency with Low T- and B-Cell Numbers	<input type="checkbox"/> D83.0 CVID with Predom Abnl of B-Cells numbers and functions
<input type="checkbox"/> D81.2 Severe Combined Immunodeficiency with Low or Normal T- and B-Cell Numbers	<input type="checkbox"/> D83.2 CVID with Autoantibodies to B- or T-Cells
<input type="checkbox"/> D81.6 Major Histocompatibility Complex Class 1 Deficiency	<input type="checkbox"/> D83.8 Other Common Variables
<input type="checkbox"/> D81.7 Major Histocompatibility Complex Class 2 Deficiency	<input type="checkbox"/> D83.9 Common Variable Immunodeficiency, Unspecified

PRESSCRIPTION**PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS****PHYSICIAN ORDERS – SCIG THERAPY (Pharmacy to provide pump and necessary supplies for administration of SCIG)**Infuse Immune Globulin 10% OR 20% _____ Gms into _____ (#) of subcutaneous sites simultaneously via pump over _____ hours

Infusion Frequency: _____ Quantity: _____ # of Refills: _____

Brand: _____

PRE-MED ORDERS

Apply topically to skin 30 minutes prior to subcutaneous needle insertion.

 Emla 2.5% Cream LMX -4 Cream Other Medications: _____**ANAPHYLAXIS ORDERS**Anaphylaxis Kit: Adult EpiPen 0.3mg/0.3mL Auto-Injector Pediatric EpiPen Jr. 0.15mg/0.3mL Auto-Injector**NURSING ORDERS**

- Provide skilled nursing care to instruct administration of SCIG therapy.
- Nurse to complete physical assessment including vital signs with each visit.
- Provide education regarding medication, disease state, adverse drug reactions and procedures, pump and pump care, & administration.
- Observe for response to therapy.
- Patient to be discharged from nursing once independent with therapy administration.

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 _____ *Dispense as written (signature required. NO STAMPS)* **OR** *Product Substitution Permitted (signature required. NO STAMPS)* **Date** _____

Prescriber's Email _____

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