IV/SC Immunoglobulin

Referral Form

Please fax completed form to:

Fax: 386-385-7871
Phone 386-456-3000
AccordSpecialty@gmail.com

Ship To/Site of Care:	☐ In Office	☐ At Home	☐ Other (list):

PATIENT INFORMATION				PRESCRIBER INFORMATION			
Name:				Prescriber Name:			
Address:				Address:			
City, State, Zip:				City, State, Zip:			
Phone:		Weight (kg)		NPI AND License:			
Alt Phone:		Gender:		Office Contact:		Email:	
DOB:		SSN:		Px:		Fax:	

CLINICAL INFORMATION				
Allergies:	☐ NKDA	☐ Allergies:		
Diagnosis:	ICD-10:	Condition:		Date of Diagnosis:
Vascular Access:	☐ Peripheral IV	☐ PICC	☐ Implant Port	☐ Other:
Prior use of Ig?	☐ No	☐ Yes	Date of Last Infusion	Date of Next Infusion:
IgA Deficiency?	☐ Yes	☐ No	IgA Lvl mg/dL	Date:

PRESCRIPTION INFORMATION

		QTY	REFILLS
MEDICATION (Check 1)	☐ IV Ig _____ g/kg Sig: _____		
	☐ Pharmacist to choose brand based on indication, availability and insurance.		
	☐ Preferred Brand (Indicate as per state law if no substitution).		
	☐ SC Ig _____ mg/kg Sig: _____		
	Product: _____ # of sites:		
Administration	☐ Per Prescribing Information as tolerated		
	☐ Other		
Pre-Medications	☐ Acetaminophen _____ mg by mouth 30 minutes prior to infusion		
	☐ Diphenhydramine _____ mg 30 minutes prior to infusion ☐ PO ☐ IV		
	☐ Lidocaine-Prilocaine 2.5% - 2.5% (For Subq inj only) — Apply small amount topically to insertion site(s) prior to needle insertion, as needed	30 g	
	☐ Other _____		
Hydration Order	Infuse _____ mg ☐ Prior to ☐ following infusion		
Flushing Protocol	☐ Sodium Chloride 0.9% ☐ 5-10 mL pre and post infusion.		
	☐ Heparin _____ units/mL _____ mL as needed		
Adverse Reactions and Anaphylaxis	1. Stop Infusion. 2. Adminster medications per protocol. 3. If life threatening reactions, notify 9-1-1 and prescriber. • Acetaminophen (Tylenol) 500 mg PO every 4 hours PRN myalgia or fever >101.3 • Diphenhydramine (Benadryl) 25 mg IV every 4 hours PRN urticaria, pruritus, or shortness of breath • If symptoms are rapidly progressing or continue after the diphenhydramine, give epinephrine (1:1000 strength) 0.3 mL SC.		
	☐ Diphenhydramine 50 mg/mL — IM/IV dose: Adult = 10-50 mg per dose every 24 hours to a max of 400 hours. Admin as IV push over 5 mins.		
	☐ Epinephrine 1:1000 (1 mg/1 mL) — SubQ Dose: Adult = 0.2-0.5 mL per dose every 15-30 mins for 3-4 doses or every 4 hours as needed.		
Pump/Supplies	☑ Pump and supplies as needed for administration and appopriate disposal of infusion medications.		
Skilled Nursing	☑ As needed for IV access, administration and appopriate clinical monitoring		

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List • Tried/Failed Therapies

PRESCRIBER SIGNATURE

By signing below, I certify that the above therapy is medically necessary and that the provided medical information is accurate to the best of my knowledge. I authorize Accord Specialty to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed. I understand that I can revoke this designation by providing notice to Accord.

Prescriber's Signature: _____ Date: _____