Intravenous Immune Globulin (IVIG) Prescription Referral Form

blue sky SPECIALTY PHARMACY

Phone: 843-352-7662 | Fax: 866-338-4245 | 1501 Belle Isle Ave #150 Mt Pleasant SC 29464

PATIENT INFORMATION - PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS

First Name: _____ Last Name: _____ Date of Birth: _____ ☐M ☐F

Street Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ SSN: _____ Patient Preferred Language: ☐English ☐Spanish ☐ _____

PRESCRIBER INFORMATION

Name: _____ DEA: _____ NPI: _____

Address: _____

Phone Number: _____ Fax Number: _____ Contact Person: _____

Office's Preferred Method of Contact: ☐Phone ☐Fax ☐Portal ☐Email: _____ ☐Other: _____

PATIENT CLINICAL INFORMATION

IMMUNOLOGY: ☐D83.9 CVID ☐D80.0 Congenital Hypogam ☐D80.1 Nonfamilial Hypogam ☐D80.6 Specific Antibody Def ☐D80.3 IgG Subclass Def ☐D81.9 SCID

NEUROLOGY: ☐G61.81 CIDP ☐G61.82 MMN ☐G35.0 MS ☐G61.0 GBS ☐G70.01 MG ☐G62.89 Small Fiber Neuropathy ☐G04.81 AutoImm Encephalitis ☐G25.82 SPS

RHEUM/DERM: ☐L12.0 Bullous Pemphigoid ☐M33.10 Other Dermatomyositis ☐M33.20 Polymyositis ☐M33.90 Dermatopolymyositis

OTHER: _____

Weight: _____ kg/lb Height: _____ ☐NKDA ☐Drug Allergies: _____

Concurrent Medications: _____ VASCULAR ACCESS: ☐Port ☐Central ☐Peripheral

Previous / Failed Medications: _____

ORDERS: Intravenous Immunoglobulin

Medication: _____

☐Specific Brand Necessary (DAW) ☐Brand Selection Permitted

SIG	QTY	RFL
☐ INDUCTION DOSE Infuse _____ gm/kg over _____ day(s)		
☐ MAINTENANCE DOSE Infuse _____ gm/kg over _____ day(s) every _____ day(s) for _____ cycle(s)		
☐ OTHER Infuse _____ gm/kg over _____ day(s) every _____ day(s) for _____ cycle(s)		

PRE MEDICATION

☐Acetaminophen 325mg Tablet [Take 2 tablets by mouth 30 minutes prior to IVIG Infusion] | Refill PRN

☐Diphenhydramine 25mg Capsule [Take 1 capsule by mouth 30 minutes prior to IVIG Infusion] | Refill PRN

☐Other: _____

HYDRATION ORDER (Optional)

☐Infuse NaCl 0.9% _____ mL IV via gravity Drip / Pump prior to IVIG Infusion

ANAPHYLAXIS PROTOCOL

☐ADULT: Epi-Pen 0.3mg Auto Injector Dual Pack [Administer intramuscularly as needed for moderate / severe ADR] | Refill PRN
Diphenhydramine 50mg/mL Vial #1 [Administer 25mg-50mg IVP as needed for moderate / severe ADR]
Diphenhydramine 25mg Capsule #2 [Administer 25mg-50mg PO as needed for mild / moderate ADR]

☐PEDIATRIC: Epi-Pen 0.15mg Auto Injector Dual Pack [Administer intramuscularly as needed for moderate / severe ADR] | Refill PRN
Diphenhydramine 50mg/mL Vial #1 [Administer 12.5mg-25mg IVP as needed for moderate / severe ADR]
Diphenhydramine Oral [Administer 12.5mg-25mg PO as needed for mild / moderate ADR]

IV ACCESS FLUSH ORDERS

Flush VAD with NaCl 0.9% 5-10mL before and after each infusion or lab draw from VAD | Refill PRN

Flush VAD with Heparin 10u/mL 3-5mL - Final flush after NaCl flush to maintain VAD as needed | Refill PRN

SUPPLIES

☒Pharmacy to provide infusion pump and infusion pump supplies for IVIG Infusion

☒Pharmacy to provide infusion catheter supplies for placement / maintenance of venous access

PRESCRIPTION SIGNATURE

Dispense as Written: _____ Substitution Permitted: _____ Date: _____

I authorize Blue Sky Specialty Pharmacy and it's representatives to act as my agent in order to initiate and execute the insurance prior authorization process / appeals if necessary, in doing so, to release clinical information via phone / fax to appropriate third party payer