vitalcare INFUSION SERVICES

Pharmacy Name: Vital Care of Tampa
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City/State/Zip: Tampa, FL 36637
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Immunoglobulin 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: _____

PER Anaphylaxis Protocol:
Adult – EpiPen 0.3 auto-injector dual pack
Pediatric – EpiPen 0.15 auto-injector dual pack
Administer intramuscularly in the event of ADR
[May repeat x 1. **Order is valid for 1 year**]. **Use generic if applicable**

Notes:

If applicable, flush intravenous access device per Home Care Services protocol:

Access	NS	Heparin 100 u/ml
Peripheral	1 - 3 ml before/after use	10 u/ml 1-2 mls after last NS flush
Midline, Central (Non-Port), PICC	NS 5 - 10 mls before/after use 10 mls after blood draw	10 u/ml 3-5 mls after last NS flush. 5 mls after blood draw
Implanted Port	5 - 10 ml before/after use 20 mls after blood draw	100 u/ml 5 mls after last NS flush. 5 mls after blood draw
Tunneled	5 - 10 mls before/after use 20 mls after blood draw	10 u/ml 3- mls after last NS flush. 5 mls after blood draw
Groshong PICC, Midline	5 - 10 ml before/after use 10 mls after blood draw	NO Heparin Needed

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

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This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.