

# IMMUNE DEFICIENCIES REFERRAL FORM



210 Rock Road | Glen Rock, NJ 07452  
TEL: 610-545-6035 | FAX: 610-545-6034  
Toll Free: 844-691-5089

Today's Date

CURRENT PATIENT  
 NEW PATIENT

July 2016

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Address \_\_\_\_\_ Apt # \_\_\_\_\_  
 Male  Female City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Daytime Tel \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_  
Ship to Patient at  Home  Work OR Patient will pick up at  Physician Office  Pharmacy Date Needed \_\_\_\_\_  
Medical History:  Cardiac Disease  Diabetes  Renal Dysfunction  IgA Deficient  
Allergies \_\_\_\_\_ Comorbidities \_\_\_\_\_  
Current Medications (if necessary, please fax a complete list) \_\_\_\_\_

Diagnosis  
 D80.0 Hereditary Hypogammaglobulinemia  D81.5 Immune Deficiency with Increased IGM  
 D83.9 Common Variable Immunodeficiency, unspecified  D82.0 Wiskott Aldrich Syndrome  
 D81.9 Combined Immunodeficiency, unspecified  ICD-10: \_\_\_\_\_ DX: \_\_\_\_\_

Insurance Carrier - Primary \_\_\_\_\_ Name of Insured \_\_\_\_\_  
Relationship \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_ Insurance Phone \_\_\_\_\_  
Rx Carrier - Secondary \_\_\_\_\_ Rx ID # \_\_\_\_\_ Rx Group # \_\_\_\_\_ RX Phone \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Office Contact \_\_\_\_\_  
Street Address \_\_\_\_\_ Suite# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Tel \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_  
License# \_\_\_\_\_ NPI# \_\_\_\_\_ UPIN# \_\_\_\_\_ DEA# \_\_\_\_\_

## PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

Is this the first dose?  Yes  No If no:  
List product \_\_\_\_\_  
Date of last infusion \_\_\_\_\_  
Next dose due \_\_\_\_\_

### ADMINISTER IVIG USING INFUSION PUMP:

2 grams/kg over \_\_\_\_\_ days, as a loading dose, then \_\_\_\_\_ grams every \_\_\_\_\_ wk(s) for \_\_\_\_\_ cycle(s)  
 \_\_\_\_\_ gm/kg or \_\_\_\_\_ grams every \_\_\_\_\_ wk(s) for \_\_\_\_\_ cycle(s)  
 Other \_\_\_\_\_

### PRE-MEDICATIONS

Diphenhydramine (Benadryl) 25-50 mg orally before infusion  
 Acetaminophen (Tylenol) 325-650 mg orally before infusion  
 Other \_\_\_\_\_

### ADVERSE/ANAPHYLACTIC REACTIONS: PER ELWYN SPECIALTY CARE PROTOCOL

Adults or Children greater than 66 pounds or 30 kg:

- For mild reaction: give Diphenhydramine 50 mg orally, IM or IV and decrease the rate of infusion.
- For moderate reaction: stop infusion, give Diphenhydramine 50mg, orally, IM or IV and contact physician
- For Severe reaction w/breathing problem: stop infusion, call 911, give Epinephrine 0.3mg/0.3ml subcutaneously, Diphenhydramine 50 mg IV or IM. Begin NSS 500ml IV at a rate of 100-150ml/hr and contact physician.

Note: **Dosage adjustment necessary for children less than 30kg or 66 pounds:** Diphenhydramine 1.25mg/kg orally, IM or IV with a maximum of 50mg. If Epinephrine is needed 0.15mg/0.15ml 1:1000 subcutaneously

Nursing: Start PIV as required for administration and nurse to administer infusion in home.

Access:  Peripheral  PICC  Port  Other \_\_\_\_\_

Flushing: Glen Rock Medical Pharmacy Protocol (Heparin, 0.9% NaCl, D5W)

Labs \_\_\_\_\_

By signing this form and utilizing our services, you are authorizing Glen Rock Medical Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

**Prescriber's Signature** (signature required. NO STAMPS) \_\_\_\_\_ **Date** \_\_\_\_\_

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Please fax completed referral form to **Glen Rock Medical Pharmacy** at **610-545-6034** Visit **www.GLENROCKMEDICALPHARMACY.com** for online fillable forms.