RE PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please Contact Us!
www.REPharmacy.com

Autoimmune Disorder Referral Form

Send your Rx to: (optional)
Select Location

Date Medication Needed: _____ Ship To: ☐ Patient's Home ☐ Prescriber's Office ☐ Pick-Up (store location): _____ Injection training by pharmacy? ❑

1) Patient & Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (Prescription and Medical) with this fax.

Patient Name: _____ Birth Date: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____ ☐ lbs. ☐ kg.
Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Insurance Info: _____ Policy Number: _____

2) Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

3) Clinical Information

Please FAX recent clinical notes, labs and/or tests, with the prescription, to expedite the prior authorization.

Other drugs used to treat patient's condition: _____
First dose of IGIV: ☐ Yes ☐ No Prior IGIV products tried: _____
Adverse reactions with previous IGIV treatments: _____

ICD-10: _____

- ❑ Acute Infective Polyneuritis (Guillain-Barre Syndrome)
- ❑ Pemphigus (Foliaceus / Vulgaris)
- ❑ Myasthenia Gravis with (Acute) Exacerbation
- ❑ Myasthenia Gravis without (Acute) Exacerbation
- ❑ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ❑ Inflammatory Polyneuropathy, Unspecified
- ❑ Dermatomyositis
- ❑ Multiple Sclerosis (MS)
- ❑ Multifocal Neuropathy (MMN)
- ❑ Pemphigoid
- ❑ Polymyositis
- ❑ Stiff-Person Syndrome
- ❑ Other:

4) Prescription Information

Administer: ☐ SCIG ☐ IGIV **Product:** ❑ Pharmacist to determine ❑ Formulation: _____

Dose: Please select option(s) and provide complete information, (pharmacy to round to the nearest 5 gram vial).

❑ Loading Dose: _____ g/kg over _____ day(s), then
❑ _____ g daily for _____ day(s) every _____ week(s) x _____ cycle(s)
❑ _____ g/kg/day x _____ day(s) every _____ week(s) x _____ cycle(s) ❑ Other regimen: _____

Infusion Rate: (Please select one and provide complete information).

☐ Pharmacist to determine ☐ Start at _____ ml/hr, then increase by _____ ml/hr every _____ minutes to maximum rate _____ ml/hr

Access: ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____

IV Maintenance (Flushing): Dispense quantity sufficient.

- Sodium Chloride 0.9% 10ml Prefilled Syringe: Flush IV access device with sodium chloride 3-10ml to maintain line patency.
- Heparin 10 units/ml 5ml Prefilled Syringe: Flush peripheral IV access device with Heparin 10 units/ml 1-5 ml as needed to maintain line patency.
- Heparin 100 units/ml 5ml Prefilled Syringe: Flush central IV access device with Heparin 100 units/ml 3-5 ml as needed to maintain line patency.

Adverse/Anaphylaxis Reaction: Anaphylaxis kit to be used in the event of anaphylactic reaction and will contain the following:

- Diphenhydramine 25mg capsule #2
- Diphenhydramine 50mg/ml 1ml vial #1
- Epinephrine Injection Auto-Injector 0.3mg (>30kg pt) or 0.15mg (<30kg pt) Two-Pack #1
- Sodium Chloride 0.9% 10ml Prefilled Syringe #4
- Sodium Chloride 0.9% 500ml Bag #1

Pre-Treatment: Dispense quantity sufficient.

Acetaminophen 325mg tablet: 1-2 tablets by mouth 15-30 minutes before each infusion ❑ Decline
Diphenhydramine 25mg capsule: 1-2 capsules by mouth 15-30 minutes before each infusion ❑ Decline
❑ Other: _____

Ancillary Supplies: Dispense ancillary supplies and equipment needed to provide home infusion therapy.

Labs: Results will be faxed to physician's office. If no frequency noted, ordered labs to be done prior to initial infusion only. Labs will not be drawn on weekends or holidays. Not appropriate for STAT labs.

Labs to be drawn: _____ Frequency of labs: _____

5) Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

_____ _____
Patient Signature **Date**

6) Prescriber Signature

Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

_____ _____ _____ _____
Dispense as written Date Substitution Permissable Date

#of Prescriptions

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.