RE PHARMACY
PASSION FOR LIFE

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

Immune Globulin Referral Form
(Immune Deficiency)

Send your Rx to:
Select Location

Date Medication Needed: _____ Ship To: ☐ Patient's Home ☐ Prescriber's Office

1. Patient Information

Patient Name: _____ Birthdate: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____ ☐ lbs. ☐ kg.
Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Alternate Caregiver Name: _____ Preferred Phone: _____
E-mail: _____
Emergency Contact Name: _____ Emergency Contact Phone: _____

2. Insurance Information

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

3. Prescriber Information

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

4. Diagnosis/Clinical Information

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

Current history of: ☐ Renal Insufficiency ☐ Diabetes ☐ CHF ☐ Thromboembolic Event ☐ HTN ☐ Other: _____
Has patient previously been on IG therapy? ☐ Yes ☐ No If yes: Date: _____ Brand: _____ Dose: _____
Does patient have a latex allergy? ☐ Yes ☐ No

Please Provide the Following Documentation:
Immune Deficiency: Detailed infection history, baseline IgG levels (including subclasses), immune response to vaccinations (including report) _____
ITP: Platelet count: _____ Post-BMT or BCT: _____
Allogeneic: _____ Autologous: _____

Pre-Protocols:
If applicable, flush intravenous access device per RE Pharmacy protocol:

Venous	NS	Heparin 100 u/ml
Peripheral	1-3 ml before/after use	1-3 ml before/after NS
Midline, Central (Non-Port), PICC	3-5 ml before/after use, 5-10 ml after blood draw	3-5 ml before/after NS
Implanted Port	5-10 ml before/after use, 10-20 ml after blood draw	5 ml after last NS
Groshong PICC, Midline	5-10 ml before/after use, 10-20 ml after blood draw	none

5. Prescription Information

ICD-10 Codes and Diagnosis
☐ C91.10 Chronic Lymphocytic Leukemia
☐ D80.1 Hypogammaglobulinemia
☐ D80.4 Selective IgM Deficiency
☐ D80.3 Other Selective Immunoglobulin Deficiency
☐ D80.0 Bruton's X-Linked Agammaglobulinemia
☐ D80.5 Hyper IgM
☐ D83.9 Common Variable Immunodeficiency (CVID)
☐ D83.8 Other Deficiency of Humoral Immunity
☐ D82.0 Wiskott-Aldrich Syndrome
☐ D80.7 Transient hypogammaglobulinemia of infancy
☐ D81.9 Combined immunodefficiency, unspecified
☐ D81.1 Combined immunodefficiency, with Low B or T Cell Numbers
☐ Z94.81Bone Marrow replaced by Transplant (BMT)
☐ B20 HIV
☐ Other ICD-10 (ICD-10 code and description) _____

Prescription Information: ☐ IVIG: _____ grams/kilogram daily for _____ day(s)
☐ OR IVIG: _____ grams/kilogram daily given over _____ non-consecutive day(s)
☐ OR Other: _____
☐ Repeat course every _____ week(s) for a total of _____ course(s).
Dose will be rounded to nearest vial size.

Route of Delivery: ☐ IV ☐ Peripheral ☐ Central
☐ Other: _____ ☐ Subcutaneous Injection

Method of Delivery:
☐ Ambulatory Pump (RE Pharmacy Suggested Protocol) ☐ Pole Mount Pump
☐ Subcutaneous Pump (Freedom 60) ☐ Other: _____

Nursing: ☐ Administration at home by RN required: ☐ Yes ☐ No
☐ In home teach by RN: ☐ Yes ☐ No
☐ Other RN services requested: _____

Administration:
Rate:
☐ Per RE Pharmacy guidelines, as tolerated
☐ Per Manufacturer guidelines, as tolerated ☐ Other: _____
# of Injection Sites: Pharmacy to Determine _____ # of Sites

Premedication Orders / Other Orders:
☐ ACETAMINOPHEN 650 MG (325mg X 2) orally PRE-IVIG ☐ DIPHENHYDRAMINE 25 MG orally PRE-IVIG
☐ Anaphylactic/Epi-Pen 0.3mg 2-Pak Auto-Injector ☐ Other: _____

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 Permissible** _____ **Date** _____

# of Prescriptions: _____

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