Immunology Referral Form (Sub-QIG & IVIG)
Fax #: 844-635-5250

Patient Information:

Patient Name: ________________________ Address: _________________________________ City: _____________ State: ___ Zip: ______

Phone(day): _________________________ Phone (night): _______________________ DOB: _________________

Rx Insurance: _______________________ ID #: __________________ Group #: _________________ Phone:_______________

Medical Insurance: ______________________ ID #: __________________ Group #: _________________ Phone :_____________

Medical Assessment:

Diagnosis (ICD-10):

___ Common Variable Immune Deficiency (D83.9)
___ Common Immunity Deficiency & SCID (D80.4)
___ Congenital Hypogammaglobulinemia (D80.0)
___ Hypogammaglobulinemia (D80.1)
___ Immunodeficiency with Increased IgM (D80.5)
___ Immunodeficiency with Predominant T-Cell Defect (D83.1)
___ Selective IgA Immunodeficiency (D80.2)
___ Selective IgM Immunodeficiency (D80.4)
___ Other Selective Immunodeficiency (D80.3)
___ Wiscott – Aldrich Syndrome (D82.0)
___ Other: ____

Allergies: ____________________________________ **Vascular Access**: ___ Peripheral ___ PICC ___ Port ___ Other: __________

Is this the first dose? ___ Yes ___ No If No, date first dose given: _________ Target Start Date: ________

Medication: Patient Current Weight: ______ lbs

Hizentra
- □ Infuse ______ grams via Freedom 60 pump every week. **Refills:** ________
- □ Other Regimen: ____

Xembify
- □ Infuse ______ grams via Freedom 60 pump every week. **Refills:** ________
- □ Other Regimen: ____

Cutaquig
- □ Infuse ______ grams via Freedom 60 pump every week. **Refills:** ________
- □ Other Regimen: ____

Administer IVIG **Product: □ Pharmacist to Determine (or) □ Brand:** _________________________

Dosage:
- □ Loading Dosage: Infuse _____ grams /kg via pump over _____ days.
- □ Maintenance Dosage: Infuse ______ grams/kg via pump every ________ weeks **Refills:** _______
- □ Other Regimen: ____

Pretreatment Orders:

___ APAP __ 325mg or __ 500mg PO 15-30 minutes before infusion.
___ Diphenhydramine 25mg PO 15-30 minutes before infusion.
___ Diphenhydramine 25mg IVP 15-30 minutes before infusion.
___ Aspirin 325mg PO 15-30 minutes before infusion.
___ Other: ____

Anaphylactic Reactions: Kits will be provided containing the following items.

Sub-Q IG: Epipen 0.3mg / 0.3 ml Auto Injector
SIG: U.D. PRN Anaphylaxis

or

IVIG: Epinephrine vial 1:1000 (1mg / ml) syringe, Diphenhydramine 25 mg capsules and 50 mg / ml 1 ml, 0.9% NaCL 500 ml bag
SIG: U.D. PRN Anaphylaxis

Flushing Protocol:

__Adult – Normal Saline (5ml) Sig: 3-5 ml IV pre / post + prn -and- Heparin 100 units / ml (5ml) Sig: 3-5 ml IV post
__Child - Normal Saline (5ml) Sig: 3-5 ml IV pre / post + prn -and- Heparin 10 units / ml Sig: 3ml IV post

*****Please include a copy of the patient's Rx insurance card, face sheet, recent clinical assessment notes, and current medication list*****

Physician Prescription Orders:

Physician Name: _________________________________ NPI #: ________________________ Nurse: ______________ Date:____________

Address: ____ Phone: __________________________ Fax: _______________________

Physician Signature: ____