

IMMUNOLOGY INFUSION Referral Form

PHONE 515.225.2930 | FAX 515.559.2495



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Patient Information

Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address			City	State	ZIP
Email	Home Phone	Work Phone		Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (if applicable)			Alt Contact Email		Alt Contact Phone

Prescriber Information

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax			
Referral Contact Email	Office Phone	Office Fax			
Practice/Facility Name	Prescriber Name/Specialty				
Address	City	State	ZIP		

*** Please include a copy of the front and back of insurance card. ***

Clinical Information – Please include applicable clinical chart notes.

Patient New to Therapy <input type="checkbox"/> Naive/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment <input type="checkbox"/>					Therapy Start Date
Sample/Starter Provided? <input type="checkbox"/> No <input type="checkbox"/> Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:	
Therapies Tried and Failed (please list medications)					
Other/Concomitant Medications (please list)					
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)					
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)					
ICD-10 Code <input type="checkbox"/> D80.0 Congenital Hypogam <input type="checkbox"/> D83.9 CVID (unspecified)		<input type="checkbox"/> D81.9 SCID (unspecified) <input type="checkbox"/> Other _____			

Prescription Information – Please Escribe if required by state law.

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Asceniv™ 10% <input type="checkbox"/> Bivigam® 10% <input type="checkbox"/> Gammagard® liquid 10% <input type="checkbox"/> Gammagard® S/D 5% <input type="checkbox"/> Gammagard® S/D 10% <input type="checkbox"/> Gammaked™ 10% <input type="checkbox"/> Gammalex® 5% <input type="checkbox"/> Gammalex® 10% <input type="checkbox"/> Gamunex® C 10% <input type="checkbox"/> Hizentra 20% <input type="checkbox"/> Octagam® 10% <input type="checkbox"/> Panzyga® 10% <input type="checkbox"/> Privilgen® 10% <input type="checkbox"/> Xembify	<input type="checkbox"/> Peripheral <input type="checkbox"/> Central <input type="checkbox"/> Port <input type="checkbox"/> Subcutaneous	Infuse _____ grams OR _____ grams per kg OR _____ mg per kg intravenously every _____ weeks Divide total dose over _____ days (where clinically appropriate, round to the nearest vial size)	Rate protocol: Titrate initial and maintenance infusions per manufacturer's product labeling. Infusion method: <input type="checkbox"/> Gravity <input type="checkbox"/> Pump	<input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year	

<input type="checkbox"/> Vascular Access Method <input type="checkbox"/> Peripheral <input type="checkbox"/> Central <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Normal Saline <input type="checkbox"/> D5W	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> Before and after infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Heparin 10 units/mL <input type="checkbox"/> Heparin 100 units/mL	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> After infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> _____	<input type="checkbox"/> After infusion <input type="checkbox"/> PRN Allergic Reaction: _____ <input type="checkbox"/> _____	<input type="checkbox"/> With each infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 325 mg <input type="checkbox"/> 650 mg <input type="checkbox"/> _____	<input type="checkbox"/> 500 mg <input type="checkbox"/> 1 gm <input type="checkbox"/> _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> _____	<input type="checkbox"/> With each infusion <input type="checkbox"/> _____
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> IM <input type="checkbox"/> SQ	<input type="checkbox"/> Adult 1:1000, 0.3 mL (>30kg/>66lbs) <input type="checkbox"/> Peds 1:2000, 0.3 mL (15-30kg/33-66lbs)	<input type="checkbox"/> PRN Anaphylaxis <input type="checkbox"/> Repeating Dose: _____	<input type="checkbox"/> Once <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Other:	<input type="checkbox"/> _____				

Prescriber Signature	Date	Supervising Physician Signature (where required by state law)	NPI #	Date
DAW (Dispense as Written)	Date	Brand Necessary (must handwrite)		

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific pharmacy and medical board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.
Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information, which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material.