Immune Globulin PID Referral Form

PREMIER PHARMACY SERVICES

Fax: 888.270.2952
Phone: 512.461.4741

DELIVER TO: ☐ Patient's Home ☐ Prescriber's Office ☐ Other:_____ ☐ HOLD SHIPMENT

PATIENT INFORMATION

Last Name: _____

First Name: _____

S.S. #:_____ Date of Birth:_____

Guardian/Caregiver:_____

Home Phone:_____ Work/Mobile Phone:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Sex: ☐ Male ☐ Female Height:_____ Weight:_____ lbs. ☐ kg. ☐

PATIENT INSURANCE INFORMATION

Medical Insurance:_____ Phone:_____

Subscriber Name:_____

Policy #:_____ Group #:_____

Prescription Card: _____ Phone:_____

Policy #:_____ BIN/PCN:_____

Medicare #:_____ Medicaid #:_____

PRESCRIBER INFORMATION

Prescriber Name:_____ ☐ MD ☐ DO ☐ NP ☐ PA

Practice Name: _____

Address:_____

City: _____ State:_____ Zip:_____

License #:_____ NPI #:_____ DEA #:_____

Phone:_____ Fax:_____

Office Contact:_____ Phone:_____

Collaborating Physician:_____

DIAGNOSIS/CLINICAL INFORMATION

(Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Medical History: ☐ Renal insufficiency ☐ Thromboembolic event ☐ CHF ☐ Diabetes ☐ HTN ☐ Other:_____

Patient recieved IVIG previously? ☐ Yes ☐ No

Lab orders:_____

IgG Level/Date:_____ IgA Level/Date: _____

Diagnosis: _____ ICD-10 Code: _____

PRESCRIPTION INFORMATION

Medication Orders: ☐ IVIG ☐ SCIG Brand _____

Dose: _____ gms/day x_____ days, every_____ days, every_____month(s)

or: _____ gms/kg/day x_____ days, every_____ days, every_____month(s)

Refills:_____

Pre-Meds:

☐ Tylenol 500-1000 mg PO PRN ☐ Benadryl 25-50 mg PO PRN

☐ IV Steroids ☐ IV Hydration

☐ Other:_____

- Anaphylaxis Kit: Epinephrine SC 1:1000-0.3mg UD PRN anaphylaxis reaction
  Diphenhydramine IV 50mg/ml UD PRN anaphylaxis reaction
  NS IV 500ml UD PRN anaphylaxis reaction
- Include 0.9 NaCl, Heparin 10-100 units/ml, and/or D5W flushes PRN to establish and maintain IV access
- Ramp infusion as directed by manufacturer as tolerated by patient
- Provide nurse for infusion of medication(s) ordered

Prescriber Signature: Prescriber, please sign and date below.

No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.

Prescriber Signature-Substitution Permissible Date Prescriber Signature-Dispense as Written Date

I authorize Premier Pharmacy Services to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.