Physician Infusions IVIG Referral Form

Patient Information

Patient Name: DOB: Height: Weight:

Address:

Phone: Email:

Insurance Information (Include a copy of the front and back of patient's insurance card)

Primary: Policy #: Group #: Ins Phone:

Secondary: Policy #: Group #: Ins Phone:

Referring Provider Office Information

Provider Name: NPI: Office Name:

Office Address:

Office Contact: Phone: Fax: Email:

Pre-medications

☐	_____ mg Acetaminophen PO	☐	_____ mg Diphenhydramine PO
☐	_____ mg Cetirizine PO	☐	_____ mg Diphenhydramine IV
☐	_____ Other IV/PO	☐	_____ mg Solumedrol IV

Prescription

Diagnosis Code: Diagnosis Description:

Allergies:

IVIG Product: ☑ Physician Infusions will select the product based on payor requirements, product availability, patient financial responsibility, and indication: Asceniv, Gammagard Liquid, Gammagard S/D, Gamunex-C, Octagam, Panzyga, Privigen.

Route: IV Refills: ____ First Infusion? Y/N Last Infusion Date (If applicable):

Loading dose included:

Loading dose: _____ g/kg OR _____ g divided over _____ days (MAX 3 days).

Maintenance dose: _____ g/kg OR _____ g divided over _____ days (MAX 3 days)

Maintenance only:

Maintenance dose: _____ g/kg OR _____ g divided over _____ days (MAX 3 days)

☑ Provide nursing care per Physician Infusions policies and procedures, including but not limited to post-infusion observation and management of adverse reactions.

Special Instructions

Physician Infusions will choose the product/biosimilar medication based on payor requirements, availability, and clinical indication.

Please send completed referral form, office notes, labs/imaging results (including TB results and dates) to Physician Infusions fax (512) 354-4938.

Prescriber Signature: _____ Prescriber Printed Name: _____ Date: _____