

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

☐

Physician Infusions to order pre-medications per standard infusion protocols/procedures

-- OR --

☐

_____ mg Acetaminophen PO

☐

_____ mg Diphenhydramine PO

☐

_____ mg Cetirizine PO

☐

_____ mg Diphenhydramine IV

☐

_____ Other IV/PO

☐

_____ mg Solumedrol IV

Required Labs

☐

Physician Infusions to order baseline labs/glucose screenings and calculate CAS score

☐

-- OR --

☐

CBC, CMP, Quantiferon TB

☐

Laboratory Frequency: _____

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: _____