

Immune Globulins Referral Form



Phone: 808-533-8887
 Fax: 808-533-1888
 E-Prescribing Available

Attention: _____ Need By Date: _____ First Ship To: Patient Physician

| | |
|----------------|--|
| Patient | Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| | Address: _____ City: _____ State: _____ Zip: _____ |
| | Home#: _____ Work #: _____ Cell#: _____ Best time to call: <input type="checkbox"/> AM <input type="checkbox"/> PM |
| | Soc. Sec #: _____ Ethnicity: _____ Primary Language: _____ |
| | Comorbidities: _____ Height: _____ Weight: _____ Date: _____ |
| | Allergies: _____ <input type="checkbox"/> NKDA |

| | |
|-----------------|--|
| Provider | Physician Name: _____ Practice Name: _____ State Lic#: _____ DEA#: _____ |
| | Address: _____ City: _____ State: _____ Zip: _____ NPI#: _____ |
| | Phone#: _____ Fax#: _____ Nurse/Key Office Contact: _____ Ext.: _____ |

| | |
|------------------|---|
| Insurance | Primary Insurance: _____ ID: _____ Phone: _____ |
| | Secondary Insurance: _____ ID: _____ Phone: _____ |

* Please provide a copy of the insurance card (front and back) and MEDICATION LIST

| | | |
|----------------------|--|---|
| Clinical Info | Please include diagnosis name and ICD-10 code | Pt Previously received IG? <input type="checkbox"/> Y <input type="checkbox"/> N Date of last infusion: _____ |
| | <input type="checkbox"/> D80.0 Congenital Hypogammaglobulinemia | Previous Products Received: _____ |
| | <input type="checkbox"/> D80.3 Other selective immunoglobulin deficiencies | <input type="checkbox"/> Diabetes <input type="checkbox"/> CHF <input type="checkbox"/> Renal Failure/Renal Insufficiency |
| | <input type="checkbox"/> D83.8 Common Variable Immune Deficiency (CVID) | Other pertinent history: _____ |
| | <input type="checkbox"/> D84.9 Unspecified Immunity Deficiency | Nursing needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> TBD |
| | <input type="checkbox"/> G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) | Agency of choice: _____ |
| | <input type="checkbox"/> G61.9 Multifocal Motor Neuropathy | If no, reason: <input type="checkbox"/> Trained to self-administer |
| | <input type="checkbox"/> D69.3 Immune Thrombocytopenic Purpura | <input type="checkbox"/> MD office to administer <input type="checkbox"/> Home health nursing already coordinated |
| | <input type="checkbox"/> M30.3 Kawasaki Disease | Agency: _____ |
| | <input type="checkbox"/> Other: ICD-10 _____ Diagnosis _____ | |

Prescription

| Medication | Strength & Directions | Quantity | Refill |
|--|---|--|--|
| <input type="checkbox"/> HIZENTRA 20% | DOSE: _____ Grams OR _____ mg/kg (Wt: _____ kg OR _____ lbs) <input type="checkbox"/> Infuse SQ every week into _____ sites over _____ hour(s) <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> GAMMAGARD LIQUID 10% <input type="checkbox"/> GAMUNEX-C 10% <input type="checkbox"/> GAMMAKED 10% (Note: SQ infusion only for primary immunodeficiency) | DOSE: _____ Grams OR _____ mg/kg (Wt: _____ kg OR _____ lbs) <input type="checkbox"/> Infuse IV every _____ week(s) over _____ hour(s) <input type="checkbox"/> Infuse SQ every week into _____ sites over _____ hour(s) <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> GAMMAGARD S/D LOW IgA (IgA less than 1 ug/ml in a 5% Solution) | DOSE: _____ Grams OR _____ mg/kg (Wt: _____ kg OR _____ lbs) <input type="checkbox"/> Infuse IV every _____ week(s) over _____ hour(s) <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> FLEBOGAMMA 5% <input type="checkbox"/> FLEBOGAMMA 10% <input type="checkbox"/> GAMMAPLEX 5% <input type="checkbox"/> PRIVIGEN 10% <input type="checkbox"/> OCTAGAM 5% | DOSE: _____ Grams OR _____ mg/kg (Wt: _____ kg OR _____ lbs) <input type="checkbox"/> Infuse IV every _____ week(s) over _____ hour(s) <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____ |
| CARIMUNE NF <input type="checkbox"/> 3% <input type="checkbox"/> 6% <input type="checkbox"/> 9% <input type="checkbox"/> 12% Reconstitute W/ <input type="checkbox"/> SWFI <input type="checkbox"/> D5W <input type="checkbox"/> NS | DOSE: _____ Grams OR _____ mg/kg (Wt: _____ kg OR _____ lbs) <input type="checkbox"/> Infuse IV every _____ week(s) over _____ hour(s) <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> GAMASTAN S/D | DOSE: _____ ml OR _____ ml/kg (Wt: _____ kg OR _____ lbs) <input type="checkbox"/> Infuse IM every _____ week(s) into _____ sites <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other: _____ | | | |

Diluents/Flushes: NS Flush D5W 50 ml for flush (For Gammagard, Gamunex, Gammaplex) Heparin 10 U/ml Flush (Peripheral Lines)
 Heparin 100 u/ml Flush (Central/ PICC Lines) NS IV Bag: 100 ml 250 ml 500 ml Other: _____

Pre-Meds: Solu-Cortef IV: _____ mg Solu-Medrol IV: _____ mg Benadryl IV: _____ mg Other: _____

Allergy/Anaphylaxis Meds: Benadryl 25-50 mg IVP # _____ doses Epinephrine (1:1000) # _____ ampules Epipen 0.3 mg Epipen Jr 0.15mg

Additional Meds: Emla Cream Other: _____

Interchange is mandated unless practitioner writes the words "BRAND MEDICALLY NECESSARY". _____

Physicians Signature(Required by Law): _____ Date: _____

I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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 (HIPPA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing the information (other than to the intended recipient) or copying the information. If you received this communication in error, please notify the sender immediately by calling 808-533-8887 or by emailing help@thehonolulu-pharmacy.com to obtain instructions as to the proper destruction of the transmitted material. Thank you.