Immune Globulins Referral Form

THE HONOLULU PHARMACY
COMPOUNDING PHARMACY & SPECIALTY PHARMACY

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: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
Home#: _____ Work #: _____ Cell#: _____ Best time to call: ☐ AM ☐ PM
Soc. Sec #: _____ Ethnicity: _____ Primary Language: _____
Comorbidities: _____ Height: _____ Weight: _____ Date: _____
Allergies: _____ ☐ 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
☐ D80.0 Congenital Hypogammaglobulinemia
☐ D80.3 Other selective immunoglobulin deficiencies
☐ D83.8 Common Variable Immune Deficiency (CVID)
☐ D84.9 Unspecified Immunity Deficiency
☐ G61.81 Chronic Inflammatory Demylinating Polyneuropathy (CIDP)
☐ G61.9 Multifocal Motor Neuropathy
☐ D69.3 Immune Thrombocytopenic Purpura
☐ M30.3 Kawasaki Disease
☐ Other: ICD-10_____Diagnosis_____

Pt Previously received IG? ☐ Y ☐ N Date of last infusion:_____
Previous Products Received: _____
☐ Diabetes ☐ CHF ☐ Renal Failure/Renal Insufficiency
Other pertinent history: _____
Nursing needed? ☐ Yes ☐ No ☐ TBD
Agency of choice: _____
If no, reason: ☐ Trained to self-administer
☐ MD office to administer ☐ Home health nursing already coordinated
Ageney: _____

Prescription

Medication	Strength & Directions	Quantity	Refill
☐ HIZENTRA 20%	DOSE: _____Grams OR _____mg/kg (Wt:_____kg OR _____lbs) ☐ Infuse SQ every week into _____ sites over _____hour(s) ☐ Other: _____	☐ 1 month ☐ 3 months ☐ Other:___	☐ 1 year ☐ Other:___
☐ GAMMAGARD LIQUID 10% ☐ GAMUNEX-C 10% ☐ GAMMAKED 10% (Note: SQ infusion only for primary immunodeficiency)	DOSE: _____Grams OR _____mg/kg (Wt:_____kg OR _____lbs) ☐ Infuse IV every _____ week(s) over _____hour(s) ☐ Infuse SQ every week into _____ sites over _____hour(s) ☐ Other: _____	☐ 1 month ☐ 3 months ☐ Other:___	☐ 1 year ☐ Other:___
☐ GAMMAGARD S/D LOW IgA (IgA less than 1 ug/ml in a 5% Solution)	DOSE: _____Grams OR _____mg/kg (Wt:_____kg OR _____lbs) ☐ Infuse IV every _____ week(s) over _____hour(s) ☐ Other: _____	☐ 1 month ☐ 3 months ☐ Other:___	☐ 1 year ☐ Other:___
☐ FLEBOGAMMA 5% ☐ FLEBOGAMMA 10% ☐ GAMMAPLEX 5% ☐ PRIVIGEN 10% ☐ OCTAGAM 5%	DOSE: _____Grams OR _____mg/kg (Wt:_____kg OR _____lbs) ☐ Infuse IV every _____ week(s) over _____hour(s) ☐ Other: _____	☐ 1 month ☐ 3 months ☐ Other:___	☐ 1 year ☐ Other:___
CARIMUNE NF ☐ 3% ☐ 6% ☐ 9% ☐ 12% Reconstitute W/: ☐ SWFI ☐ D5W ☐ NS	DOSE: _____Grams OR _____mg/kg (Wt:_____kg OR _____lbs) ☐ Infuse IV every _____ week(s) over _____hour(s) ☐ Other: _____	☐ 1 month ☐ 3 months ☐ Other:___	☐ 1 year ☐ Other:___
☐ GAMASTAN S/D	DOSE: _____ml OR _____ml/kg (Wt:_____kg OR _____lbs) ☐ Infuse IM every _____ week(s) into _____ sites ☐ Other: _____	☐ 1 month ☐ 3 months ☐ Other:___	☐ 1 year ☐ Other:___
☐ 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.