



**Locations: Nashville, Clarksville  
Bowling Green, Russellville, Smiths Grove  
Elizabethtown, Radcliff, Louisville**

**Fax: 931-241-5654, Phone: 931-241-5655**

**Immunoglobulin Referral Form**

Patient Name		Home Phone	
Date of Birth		Mobile or Work Phone	
Patient Home Address		City	State Zip
Primary Insurance Name			
Primary Insurance ID		Primary Insurance Group	
Insured Name		Insured DOB	
Secondary Insurance Name		Insurance ID	Insurance Group
Secondary Insurance ID		Secondary Insurance Group	
Ordering Physician's Name		NPI	
Address		City	State Zip
Phone		Fax	

**Please fax the following information:** History and Physical Pertinent Lab Work Front & Back copy(s) of patient's insurance card(s)

**Prescription**

<b>Intravenous Immunoglobulin</b> 0.4 gm/kg 1 gm/kg 2 gm/kg _____ grams Infuse: IV daily x ____ day(s); repeat every ____ week(s) x ____ cycles Other: _____	<b>Subcutaneous Immunoglobulin</b> Infuse _____ grams OR _____ mls using _____ sites _____ time(s) per week for _____ months.
Hydration order: _____ mls NSiv to be infused prior/post IVIG. Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion Diphenhydramine 25mg PO 30 mins prior to infusion	
Other Pre-medications: _____	

**Clinical Information**

Patient Weight	Height	Allergies	
IV access [for IVIG patients only]: _____		Nurse to place PIV prior to therapy	
<b>Diagnosis</b>	<b>ICD-10</b>	<b>Diagnosis</b>	<b>ICD-10</b>
<b>Neuromuscular:</b>		<b>Immune Deficiency:</b>	
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	CVID w/ Predominant Immunoregulatory T-Cell Disorders	D83.1
Guillain-Barre Syndrome (GBS)	G61.0	Combined Immunodeficiency, Unspecified	D81.9
Multifocal Motor Neuropathy	G61.82	Common variable Immunodeficiency, Unspecified	D83.9
Myasthenia Gravis (MG)	G70.0	Hereditary Hypogammaglobulinemia	D80.0
Myasthenia Gravis with (Acute) Exacerbation	G70.01	Immunodeficiency with Increased IgM	D80.5
Autoimmune Encephalopathy	G04.81	Nonfamilial Hypogammaglobulinemia	D80.1
Inflammatory Neuropathies	G61.89	Other Combined Immunodeficiencies	D81.89
Relapsing Remitting Multiple Sclerosis (RRMS)	G35	Other Common Variable Immunodeficiencies	D83.9
Stiff Person Syndrome	G25.82	Pemphigoid	L12.0
<b>Other:</b>		Pemphigus	L10.9
Idiopathic Thrombocytopenic Purpura	D69.3	SCID with Low or Normal B-Cell Numbers	D81.2
Dermatopolymyositis	M33.90	SCID with T- and B- Cell Numbers	D81.1
Polymyositis	M33.20	Selective Deficiency of IgG Subclasses	D80.3
		Specific Antibody Deficiency	D80.6
		Systemic Lupus Erythematosus (SLE)	M32.9

<b>Please Draw:</b> CBC/diff _____ CMP _____ IgG w/ subclasses 1-4 _____ Quant. Ig _____ Frequency: _____	<b>Anaphylaxis Protocol:</b> <b>PER Pharmacy Protocol</b> <b>PER Prescriber Protocol:</b> _____
---	---

<b>Notes:</b>   	<b>Flushing Protocol:</b>  <b>PER Pharmacy Protocol</b> <b>PER Prescriber Protocol:</b> _____
---------------------------	--

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: \_\_\_\_\_  
Date: \_\_\_\_\_