Tel: (844) 671-2600
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info@medrxinfusion.com

Immunoglobulin Referral Form

Administer At: Patien's Home Prescriber's Office Other:__________ Hold shipment until notified by prescriber Anticipated Start Date:__________

1. Patient Information

Last Name: Home Phone:__________ Work / Mobile Phone:__________

First Name:__________ Home Address:__________

Date of Birth:__________ City:__________ State:__________ Zip:__________

Sex: Male: Female: Height:__________ Weight:__________ lb kg

2. Prescriber Information

Prescriber Name:__________ MD DO NP PA License#:__________ NPI#:__________ DEA#:__________

Address:__________ Phone:__________ Fax:__________

City:__________ State:__________ Zip:__________ Office Contact:__________ Phone:__________

3. Diagnosis and Clinical Information

(Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Patient recieved IVIG/SCIG previously? Yes No

Other Dugs Used to Treat Patient's Condition:__________

Meds Tried/Failed:__________

Allergies:__________

Diagnosis (ICD 10 Code):__________

4. Prescription Information

Product: Pharmacist to determine (or) Formulation:__________

Medication Orders	Brand	Therapy Regimen	Refills
IVIG SCIG		Dose: ________g/kg/day x ________days, every ________weeks	
IVIG SCIG		Dose: ________g/kg/day x ________days, every ________weeks	

Pre-Meds:

Tylenol 500-1000 mg PO PRN

Benadryl 25-50 mg PO PRN

IV Steroids:__________

IV Hydration:__________

Other:__________

Dispense supplies necessary for administration and hazardous waste disposal.

Anaphylaxis Kit:
- Epinephrine IM / SC 1: 1000-0.3 mg UD PRN anaphylaxis reaction
- Epinephrine injection, USP auto-injector IM / UD PRN anaphylaxis reaction
- Diphenhydramine IV 50 mg/ml UD PRN anaphylaxis reaction
- NS IV 500 ml UD PRN anaphylaxis reaction

Include 0.9 NaCl, Heparin 10-100 units/mL, and/or D5W flushes PRN to establish and maintain IV access

Ramp infusion as directed by manufacturer as tolerated by patient

Provide nurse for infusion of medication(s) ordered

Prescriber Authorization

(No stamps. Signature and date must be completed in prescriber's handwriting)

I authorize MedRX Infusion Clinical Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date ______ / ______ / ______