

# Intravenous Immune Globulin (IVIG) Referral Form

3233 Corporate Ct.  
Ellicott City, MD 21043



Send your Rx to:

Fax Number: 410-203-1515  
Phone Number: 410-203-1010

Toll Free Number:  
1-833-4-LIFELINE

NPI: 1568975464

If you have questions or concerns, please contact us.

Date Medication Needed: \_\_\_\_\_ Ship To:  Patient's Home  Prescriber's Office

Injection training by pharmacy?

## 1: Patient Information

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_  lbs.  kg.  
Soc. Sec. #: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_ Known Allergies: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Alternate Caregiver Name: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_

**Insurance Information:** Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

## 2: Prescriber Information

Provider Name: \_\_\_\_\_ DEA#: \_\_\_\_\_ NPI#: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Key Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

## 3: Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

C91.10 Chronic lymphocytic leukemia of B-cell type not having achieved remission	D81.89 Other combined immunodeficiencies	G35 MS (Relapsing Remitting)
D69.3 Immune thrombocytopenic purpura	D81.9 SCID (Unspecified)	G61.0 GBS
D80.0 Congenital Hypogam	D82.0 Wiskott-Aldrich syndrome	G61.81 CIPD
D80.2 Selective deficiency of IgA	D82.1 De George's syndrome	G61.89 MMN
D80.4 Selective deficiency of IgM	D82.4 Hyperimmunoglobulin E syndrome	G70.00 MG without acute exacerbation G70.01
D80.5 Immunodeficiency with increased IgM	D83.0 Common Variable Immunodeficiency with Predominant abnormalities of B cell numbers and function	MG with acute exacerbation
D80.6 Antibody deficiency with near-normal Immunoglobulins or with hyperimmunoglobulinemia	D83.1 Common Variable Immunodeficiency with predominant Immunoregulatory T cell disorders	M33.20 Polymyositis
D80.7 Transient hypogammaglobulinemia	D83.2 Common Variable Immunodeficiency with autoantibodies to B or T cells	M33.90 Dermatomyositis
D81.0 SCID with reticular dysgenesis	D83.8 Other Common Variable Immunodeficiency D83.9	Other ICD-Code: _____
D81.2 SCID with low or normal B cell numbers	Common Variable Immunodeficiency, unspecified	Prior failed medications: _____
D81.5 Purine nucleoside phosphorylase deficiency	G11.3 Cerebellar ataxia with defective DNA	
D81.6 Major histocompatibility complex class I		
D81.7 Major histocompatibility complex class II		

## 4: Pre-medications/Adverse Reaction Medications

Medication	Route	Dose/Strength	Sig (Please specify)	Qty.	Refills
Diphenhydramine	PO	25 mg	PRN mild/mod allergic reaction: take _____ tablet(s)		
	IV	50 mg	Premed to be given 30 minutes prior to the infusion: take _____ tablet(s) Other: _____		
Fexofenadine	PO	180 mg	PRN mild/mod allergic reaction: take _____ tablet(s) Other: _____		
Cetirizine	PO	10 mg	PRN mild/mod allergic reaction: take _____ tablet(s) Other: _____		
Methylprednisolone	IV	40 mg/mL	PRN mild/mod allergic reaction: Inject 125 mg slow IV push over 5 minutes Inject _____mg slow IV push over _____ minutes		
		80 mg/mL			
Acetaminophen	PO	325 mg 625 mg	PRN for fever, chills, and headache: take _____ tablet(s) Other: _____		
Epinephrine	IM	0.15 mg/0.3 mL 0.3 mg/0.3 mL	For adults weighing > or = 30kg: administer a single dose, may repeat one time For adults weighing < 30kg: administer a single dose, may repeat one time		
Ondansetron	ODT	4 mg	PRN for nausea and vomiting: take _____ tablet(s) Inject _____mg slow IV push over _____ minutes		
	IV	8 mg			
Lidocaine	TOP	1.8%	Apply to injection sites at least 1 hour before Other: _____		
		5%			
Other: _____					

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## 5. Administration assistance/ Patient Support and Injection Training Authorization

Assistance required  No, assistance needed

I authorize Lifeline Specialty Pharmacy to enroll the patient in the pharmaceutical manufacturer support program that pertains to the prescribed therapy. The purpose of this enrollment is to assist the patient in receiving services, like injection training and administration of the therapy by a nurse. The patient also authorizes the pharmacy to transmit any pertinent information that the manufacturer needs to effectively provide the medications and services that are available with the therapy, as well as, to use unidentifiable data to conduct market research. The manufacturer may contact me with information for research and educational purposes. The patient can revoke this authorization without any effect to the patient's ability to acquire the therapy. If the patient chooses to revoke this authorization, he/she may do so by writing a letter to Lifeline Specialty Pharmacy at 3233 Corporate Court, Ellicott City, MD, 21044.

## 6: Prescription Information |

Medication	Route	Dose/Strength	Sig (Please include cycle)	Qty.	Refills
Flebogamma DIF	IV	5% (50 mg/mL) 10% (100 mg/mL)	Infuse _____ grams per kg every _____ weeks (Inf. rate: initial _____ MD: _____) Other: _____		
Gammagard Liquid	IV SQ	10% (100 mg/mL)	Infuse _____ grams per kg every _____ weeks (Inf. rate: initial _____ MD: _____) Other: _____		
Gammaked	IV SQ	10% (100 mg/mL)	Infuse _____ grams per kg every _____ weeks (Inf. rate: initial _____ MD: _____) Other: _____		
Gamunex-C	IV SQ	10% (100 mg/mL)	Infuse _____ grams per kg every _____ weeks (Inf. rate: initial _____ MD: _____) Other: _____		
Privigen	IV	10% (0.1 g/mL)	Infuse _____ grams per kg every _____ weeks (Inf. rate: initial _____ MD: _____) Other: _____		
Hizentra	SQ	20% (0.2 g/mL)	Infuse _____ grams per kg _____ times every _____ weeks or _____ days Other: _____		
GamaSTAN S/D	IM		Administer a dose of _____ mL per kg; repeat every _____ months (if required) Other: _____		
CytoGam	IV	2500 mg IgG	Initial: _____ mg/kg/hr for _____ mins, _____ mg/kg/hr for _____ mins, then _____ mg/kg/hr for _____ mins to complete; Subsequent: _____ mg/kg/hr for _____ mins, _____ mg/kg/hr for _____ mins, then _____ mg/kg/hr for _____ mins to complete		
HepaGamB	IV IM	1 mL 5 mL	Administer a dose of _____ mL per kg or _____ mL every _____ day or _____ week from Day _____ to _____; _____		
KEDRAB	IM	300 IU/ 2 mL 1,500 IU/ 10 mL	Administer a dose of _____ IU per kg Other: _____		
Nabi-HB	IM	1 mL 5 mL	Administer a dose of _____ mL Other: _____		
Rhophylac	IV IM	1,500 IU (300 mcg) -per 2 mL prefilled	Inject _____ IU/kg or _____ IU (Inf. rate: _____ mL per _____ seconds) Other: _____		
Varizig	IM	≥125 IU	Based on patient's weight _____ kg: Administer a single dose of _____ IU or _____ mL		
WinRho SDF Liquid	IV IM	600 IU 5,000 IU 1,500 IU 15,000 IU 2,500 IU	Inject _____ IU/kg or _____ mcg/kg (Inf. rate: _____) Other: _____		
Atgam	IV	5 mg/mL	Infuse _____ mg per kg every _____ days Other: _____		
ANAVIP	IV		Infuse _____ vial(s) every _____ hours for _____ hours		
CroFab	IV		Infuse _____ vial(s) every _____ hours for _____ hours		
DigiFab	IV	40 mg	Infuse _____ vial(s) every _____ hours for _____ hours		
Thymoglobulin	IV	25 mg/10mL	Infuse _____ mg/kg daily for _____ days Other: _____		
Other:					

**Patient Support Programs:** Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Prescriber Signature:** Prescriber, please sign and date below

Dispense as written

Date \_\_\_\_\_

Substitution Permissible

Date \_\_\_\_\_

**IMPORTANT NOTICE:** This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: \_\_\_\_\_