MEDQUICK PHARMACY

Immune Globin (IVIG) Referral Form

Phone 877.421.3405 Fax 877.421.3406
546 West Las Tunas Drive, San Gabriel, CA 91776

Patient Information

Name (last, first)	Phone ❑Home ❑Cell	Date of Birth
Home Address, City, State		ZIP
Shipping Address, City, State (if different from above)		ZIP

Social Security Number	❑ Male ❑ Female	Allergies

Healthcare Provider Information

Prescriber's First and Last Name	Phone	Fax
Address, City, State		ZIP

Nurse/Key Contact	Physician NPI	DEA	License

Insurance Information *(attach copies of card and fax along with this form)*

Primary Insurance	Phone	Name (Insured ❑ Self, ❑ Spouse, ❑ Dependent)	ID Number	RXGRP
Secondary Insurance	Phone	Name (Insured ❑ Self, ❑ Spouse, ❑ Dependent)	ID Number	RXGRP
Pharmacy Benefit Card	RXBIN	Member/Subscriber ID Number	RXGRP	PCN

Additional Information

Today's Date	Start Date	Deliver to: ❑ Home ❑ Physician	Nurse Training Needed? ❑ Yes ❑ No	Special Instructions

Diagnosis

❑ 357.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
❑ 279.04 Congenital Hypogammaglobulinemia
❑ 279.05 Immunodeficiency with increased IgM
❑ 279.12 Wiskott-Aldrich Syndrome
❑ 279.2 Combined Immunity Deficiency
❑ 358.00 Myasthenia Gravis without acute exacerbation
❑ 358.01 Myasthenia Gravis with acute exacerbation
❑ 340.0 Multiple Sclerosis relapsing/remitting only
❑ 356.4 Polyneuropathy Idiopathic, Progressive
❑ 357.9 Multifocal Motor Neuropathy
❑ 279.06 Common Variable Immune Deficiency (CVID)
IgG Level:_____ Date: _____
❑ 279.00 Hypogammaglobulinemia
IgG Level:_____ Date: _____
❑ Other:_____
ICD-9 Codes:_____

Physicians Orders *(Please check the following)*

❑ IgIV Therapy _____grams daily for _____day(s) every _____week(s)
Or _____ grams every _____ week(s) Refill: _____ times
❑ Dispense: _____
Access Device: ❑ Peripheral ❑ PICC ❑ Port ❑ Other:_____
Flushing: Per SASH Protocol (1-3ml for peripheral, 5ml for central/port, 0.9% NaCl)
Adverse/Anaphylactic Reactions: Anaphylaxis kit will be provided containing:
Diphenhydramine 25mg capsules and/or 50mg/ml 1ml vial
Epinephrine Injection Auto-Injector 0.3mg(>30kg pt) or 0.15mg(<30kg pt) Two-Pack
Medical/Surgical Supplies needed for administration:
❑ IV Pole ❑ IV Pump ❑ Syringe, Needles, Dressing Kits, IV Start Kits, Alcohol Pads, etc, Per infusion Protocols

Pre-Treatment:
❑ APAP 325mg 1-2 PO 15 mins before infusion (Disp: Match per Infusion)
❑ Diphenhydramine 25mg 15 mins before infusion (Disp: Match per Infusion)
❑ Other:_____
Labs:
Results will be faxed to pharmacy and physician's office. If no frequency noted, ordered labs to be done prior to initial infusion only.
❑ BUN/SCr ❑ Chem 7 ❑ Q 3 mos ❑ Q 6 mos ❑ Q 1 year
❑ Labs to be drawn at physician's office
❑ Other:_____
Nursing:
❑ Skilled Nursing Visit to assess & administer IVIG therapy
❑ Agency: _____ Phone _____
❑ Nurse Contact; _____
❑ MD Office to administer

When sending a referral please include all clinical information, including recent lab values, relevant to performing a prior authorization and copies of patient's insurance cards

Physician Signature:_____ **Date** ____/____/____

I authorize MedQuick Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.