One Source Homecare - IVIG Order Form

Fax Referral To: 866-466-2270 **Toll Free Phone:** 866-466-2273

E-mail Referral To: Info@onesourcehomecare.org

IV-SQ Immune Globulin Referral

1 PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐Male ☐Female
E-mail: _____
Last Four of SS #: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

3 INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

Please fax prescription for drug, flushes and supplies

4 DIAGNOSIS AND CLINICAL INFORMATION

☐ Primary Immune Deficiency (please state specific condition and ICD-9 code): _____

☐ 204.9 Chronic Lymphocytic Leukemia
☐ 279 Immune Mechanism Disorder
☐ 279.0 Deficiency of Humoral Immunity
☐ 279.06 Common Variable Immunodeficiency
☐ 279.3 Immunity Deficiency NOS
☐ 287.31 Idiopathic Thrombocytopenia
☐ 357.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ 446.1 Kawasaki Syndrome
☐ Other: _____

Patient previously received IVIG? ☐Yes ☐No
Date of last infusion: _____
Height: _____ In
Weight: _____ kg / lbs
Allergies: _____
Nursing needed? ☐ Yes ☐ No ☐ TBD
Agency of choice: _____
If no, reason: ☐ Trained to self-administer
☐MD office to administer to patient
☐ Home health nursing already coordinated
Agency: _____

5 PRESCRIPTION INFORMATION

MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Carimune ☐ Flebogamma DIF ☐ 5% ☐ 10% ☐ GamaSTAN S/D ☐ Gammagard Liq 10% ☐ Gammagard S/D ☐ Gammaked 10% ☐ Gammaplex 5% ☐ Gamunex-C 10% ☐ Hizentra 20% ☐ Octagam 5% ☐ Privigen 10%	☐ IV ☐ SQ ☐ IM	_____ grams		☐ 1 month ☐ 3 months ☐ Other: _____	☐ 1 year ☐ Other: _____
☐ Normal Saline ☐ Heparin 10 units/mL ☐ Heparin 100 units/mL ☐ Other: _____	☐ IV				
☐ Diphenhydramine	☐ PO ☐ IV	☐ 25-52mg ☐ Other: _____	☐ Pre-Med ☐ Other: _____		
☐ Acetaminophen	☐ PO	☐ 325 mg ☐ 500 mg ☐ 1 gram ☐ Other: _____	☐ Pre-Med ☐ Other: _____	☐ Once ☐ 1 month ☐ 3 month ☐ Other: _____	☐ 1 year ☐ Other: _____
☐ Epi-Pen ☐ Epi-Pen Jr.	☐IM	☐ One Pen ☐Two Pens ☐ Other: _____	☐ PRN Anaphylaxis ☐ Other: _____		
☐ Other:					

☐ Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

6

PHYSICIAN SIGNATURE REQUIRED

X _____ (Date)
DISPENSE AS WRITTEN

X _____ (Date)
PRODUCT SUBSTITUTION PERMITTED