BIOMATRIX SpRx

IVIG - NEUROLOGY/IMMUNOLOGY REFERRAL FORM *(PAGE 1 OF 2)*

TODAY'S DATE ________________

☐ **CURRENT PATIENT** ☐ **NEW PATIENT**

PLEASE FAX REFERRAL FORM TO:

☐ **BiologicTx - NJ** TEL: 877-567-8087 FAX: 877-567-8089
☐ **BiologicTx - CA** TEL: 800-404-1963 FAX: 800-404-4595
☐ **BiologicTx - IL** TEL: 888-892-7607 FAX: 877-567-8089
☐ **Decillion Healthcare** TEL: 800-622-9321 FAX: 866-548-8849
☐ **Elwyn Specialty Care** TEL: 855-359-9679 FAX: 610-545-6030
☐ **Factor Support Network** TEL: 877-376-4968 FAX: 805-482-6324
☐ **Matrix Health** TEL: 877-337-3002 FAX: 888-385-2805
☐ **Med Center Specialty Pharmacy** TEL: 855-633-5633 FAX: 304-344-0655
☐ **MedEx BioCare** TEL: 800-962-6339 FAX: 901-382-3091

Patient Name ________________ SS# ________ DOB ________ ☐ Male ☐ Female
Street Address ________________ Apt# ______ City ________ State ______ Zip ______
Daytime Tel ________ Cell ________ Email ________ Height ______ Weight ______ BSA ______
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone ________
Allergies ________________ Comorbidities ________________
Current Medications (if necessary, please fax a complete list) ________________

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT
________	________	________	________

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐ ________ # ________	☐ ________ # ________	☐ ________ # ________
☐ ________ # ________	☐ ________ # ________	☐ ________ # ________
☐ ________ # ________	☐ ________ # ________	☐ ________ # ________

Insured's Name ________________ Relation to Patient ________________
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ________ Prescription Card ☐ Yes ☐ No If Yes, Carrier ________
Tel ________ Fax ________ Policy/Group# ________
Bin# ________ Pcn# ________ RXID# ________ RX Group# ________

ICD-10 Code

☐ D80.0 Hereditary Hypogammaglobulinemia
☐ D80.1 Nonfamilial Hypogammaglobulinema
☐ D81.0 Severe Combined Immunodefic. w/ Reticular Dysgenesis
☐ D81.1 Immunodeficiency with Low T-and B-Cell Numbers
☐ D81.2 Severe Combined Immunodeficiency with Low/Normal T- and B-Cell Numbers
☐ D81.5 Immune Deficiency with Increased IGm
☐ D81.6 Major Histocompatability Complex Class 1 Deficiency
☐ D81.7 Major Histocompatability Complex Class 2 Deficiency
☐ D81.89 Other Combined Immunodeficiences
☐ D81.9 Combined Immunodeficiency, unspecified
☐ D82.0 Wiskott Aldrich Syndrome
☐ D83.0 CVID with Predom Abnlt of B-Cell Numbers & Function
☐ D83.2 CVID with Autoantibodies to B- or T-Cells
☐ D83.8 Other Common Variable Immunodeficiences
☐ D83.9 Common Variable Immunodeficiency, unspecified
☐ G25.82 Stiff-Person Syndrome
☐ G35 Multiple Sclerosis
☐ G61.0 Gullian-Barre Syndrome
☐ G61.81 CIDP
☐ G61.881 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ G61.89 Other Inflammatory Polyneuropathies
☐ G62.89 Other Specified Polyneuropathies
☐ G64 Other Disorders of Peripheral Nervous System
☐ G69.49 Other Primary Thrombocytopenia
☐ G70.01 Myasthenia Gravis with (Acute) Exacerbation
☐ G70.80 Lambert-Eaton syndrome, unspecified
☐ M33.20 Polymyositis, organ involvement, unspecified
☐ M36.0 Dermatomyositis
☐ P61.0 Transient Neonatal Thrombocytopenia
☐ Other: ________________

Medical History: ☐ Diabetes ☐ Hypertension ☐ Other: ________________ Blood Type: ________

IGA Deficiency (Recent Level): ________________

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

Is this the first dose? ☐ Yes ☐ No
If no: List product________ Date of last infusion________ Next dose due________

PHYSICIAN ORDERS

☐ IVIG Therapy: Infuse IVIG ______ GMS or ______ gm/kg IV over ______ hours or as tolerated.
If not specified, will follow company policy for IVIG administration.
Frequency: ________________ QTY/# of Refills: ________
☐ Pharmacy to select Product ☐ Specific Brand desired, please specify: ________________
☐ Other Therapy: Infuse ________________ Dose________ Frequency ________
Route of Administration: ________________ Infusion Rate: ________ QTY/# of Refills: ________
☐ Pharmacy to select Product ☐ Specific Brand desired, please specify: ________________

PRE-MEDICATIONS

Pre-Medicate 30 minutes prior.

☐ Diphenhydramine (Benadryl) _____ mg orally
☐ Acetaminophen (Tylenol) _____ mg
☐ Prednisone (Cortisone) _____ mg orally
☐ Other ________________

COMPLETE PAGE 2 WITH CLINICAL INFORMATION

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Patient Name ____ DOB _______________

PRESCRIPTION — PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

ANAPHYLAXIS/FLUSH/SUPPLY ORDERS
Equipment (pole, pump)/Supplies will be provided as per therapy requirements.

Anaphylaxis Kit: ☐ Adult ☐ Pediatric

Adults or Children greater than 66 pounds or 30kg

- For mild reaction: give Diphenhydramine 50mg orally, IM , or IV and decrease the rate of infusion
- For moderate reaction: stop infusion, give Diphenhydramine 50mg, orally, IM or IV and contact physician
- For severe reaction with breathing problem: stop infusion, call 911, give Epinephrine 0.3mg/0.3ml subcutaneously, Diphenhydramine 50mg IV or IM and contact physician

*Note: **Dosage adjustment necessary for children less than 30 kg or 66 pounds**: Diphenhydramine 1.25mg/kg orally, IM or IV with a maximum of 50mg.*

If Epinephrine is needed 0.15mg/0.15ml subcutaneously

Flush Orders (PRN Catheter Maintenance):

☐ Saline 0.9% Flush 5ml or D5W (determined by IVIG compatibility)
☐ Heparin Flush 10 units/ml - 5ml
☐ Heparin Flush 100 units/ml - 5ml

LAB WORK ORDERS
☐ Lab Orders: ____
☐ Frequency of Lab Work: ____

NURSING ORDERS
☐ Provide skilled nursing care to complete therapy.
☐ Baseline Vital Signs: BP, HR, Temp prior to infusion, every 15 minutes x 1st hour and each subsequent hour until completion.
☐ Provide education regarding medication, disease state, adverse drug reactions, and administration.
☐ Observe for response to therapy.
☐ IV Access: ______________________________ Location: ____________________
☐ Maintain IV Access according to company policy and procedures.
Hold Infusion If: ______________ BP systolic above 180 mm Hg or ______________ BP diastolic above 105 mm Hg
☐ Nurse/Nursing agency to contact transplant coordinator at least 24 hours prior to each infusion with date and time to be infused.

PLEASE INCLUDE THE FOLLOWING
☐ MD Prescription ☐ PRA Level (attach copy of results)
☐ Complete Patient History, including any previous transplants and dates, lab results

COMMENTS
____
____
____
____
____
____
____

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) ________ *Dispense as written* ________ **Date** ____________

Prescriber's Signature (signature required. NO STAMPS) ________ *Product Substition Permitted* ________ **Date** ____________

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