MED CENTER SPECIALTY PHARMACY
A BIOMATRIX Company

FEB 2018

IVIG NEUROLOGY REFERRAL FORM

3100 MacCorkle Avenue S.E. | Suite 100
Charleston, WV 25304
TEL: 304-344-8021 | FAX: 304-344-0655

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

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_____
Medical History: ☐ Cardiac Disease ☐ Diabetes ☐ Renal Dysfunction ☐ IgA Deficient
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION

☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____

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 Diagnosis Code ☐ G61.0 Guillain-Barre Syndrome
☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ G61.9 Inflammatory Polyneuropathy, unspecified
☐ G70.01 Myasthenia Gravis with (Acute) Exacerbation
☐ M33.20 Polymyositis, organ involvement unspecified
☐ G70.80 Lambert-Eaton Syndrome, unspecified
☐ M36.0 Dermatomyositis
☐ G25.82 Stiff-Person Syndrome
☐ G35 Multiple Sclerosis (MS)
☐ ICD-10:_____ DX:_____

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 _____

ADMINISTER IVIG USING INFUSION PUMP:

☐ 2 grams/kg over _____ days, as a loading dose, then _____ grams every _____ wk(s) for _____ cycle(s)
☐ _____ gm/kg or _____ grams _____ every _____ wk(s) for _____ cycle(s)
☐ Other _____

PRE-MEDICATIONS

☐ Diphenhydramine (Benadryl) 25-50 mg orally before infusion
☐ Acetaminophen (Tylenol) 325-650 mg orally before infusion
☐ Other _____

ADVERSE/ANAPHYLACTIC REACTIONS: PER ELWYN SPECIALTY CARE PROTOCOL

Adults or Children greater than 66 pounds or 30 kg:

- For mild reaction: give Diphenhydramine 50 mg 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 w/breathing problem: stop infusion, call 911, give Epinephrine 0.3mg/0.3ml subcutaneously, Diphenhydramine 50 mg IV or IM. Begin NSS 500ml IV at a rate of 100-150ml/hr and contact physician.

Note: **Dosage adjustment necessary for children less than 30kg or 66 pounds:** Diphenhydramine 1.25mg/kg orally, IM or IV with a maximum of 50mg. If Epinephrine is needed 0.15mg/0.15ml 1:1000 subcutaneously

Nursing: Start PIV as required for administration and nurse to administer infusion in home.
Access: ☐ Peripheral ☐ PICC ☐ Port ☐ Other _____
Flushing: Elwyn Specialty Care Protocol (Heparin, 0.9% NaCl, D5W)
Labs_____

By signing this form and utilizing our services, you are authorizing Med Center Specialty Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

Please fax completed referral form to **Med Center Specialty Pharmacy** at **304-344-0655** Visit **www.MEDCENTERSPECIALTYPHARMACY.com** for online fillable forms.