IVIG Detailed Written Order
Fax: 877-438-9380

CONTINUUM Health

Patient Name: ______________________ Referral Date: ______________________

Date of Birth: ______________________ Office Contact and Phone Number: ______________________

Please Circle the Applicable Diagnosis Code:

Pulmonological/Immunological Diagnosis (ICD Codes)

- Immunodeficiency with increased IgM (279.05/D80.5)
- Wiskott-Aldrich Syndrome (279.12/D82.0)
- Selective IgA Immunodeficiency (279.01/D80.2)
- Congenital Hypogammaglobulinemia (294.04/D80.0)
- Common Variable Immunodeficiency (279.06/D83.9)

Neurological Diagnosis (ICD Codes)

- Myasthenia Gravis (358.0/G70.0)
- Peripheral Neuropathy (356.9/G60.9)
- Guillian-Barre (357.0/G61.0)
- CIDP (357.81/G61.81)
- Polymyositis (714.0/M06.9)

Dermatological/Rheumatological Diagnosis (ICD Codes)

- Pemphigus Vulgaris (694.4/L10.0)
- Psoriatic Arthropathy (696.0/L40.5)
- Other Psoriasis (696.1/L40.8)
- Dermatomyositis (710.3/M33.90)
- Polymyositis (714.0/M06.9)
- Vasculitis (447.6/I77.6)

Subcutaneous IG Replacement Therapy (ICD Codes)

- Common Variable Immunodeficiency (279.06/D83.9)
- Congenital Hypogammaglobulinemia (279.04/D80.0)
- Immunodeficiency with Increased IgM (279.05/D80.5)

Other Diagnosis: ______________________

Order:

___IV E0781 Pump, A4221 cath supplies, A4222 pump supplies

___SUB-Q K0552 Pump, A4221 Cath supplies, A4222 pump supplies

IV:

__ **Gamunex-C (J1561)**
__ Gammagard (J1569)
__ Privigen (J1459)
__ Panzyga (J1599)
_______ (other)

SC:

__ Hizentra (J1559)
__ Hyqvia (J1575)
__ Cutaquig (J3590)
_______ (other)

Dose: _________grams/kg
________kg=_______GRAMS

Frequency:

Over______hrs OR Over_________ days
Every_____days
______ refills

Date of Last Dose:____________________
Due Date of Next Infusion:____________________
Lab Orders:____________________
Fax Lab Results To:____________________

Ancillary orders will include:

NaCl 0.9% 5-10ml IV before and after infusion
Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN
Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN
All infusion supplies necessary to administer the medication
Anaphylaxis Kit

Additional Information to process Referral:

Immunological Diagnosis:

*Documents showing recurring infections and a need for long term antibiotics (when and what)
*Copy of related labs (IgG, IgA, IgM)
*Tried and failed therapies

Neurological Diagnosis:

*Need a copy of all studies supporting dx (EMG, NCS, CSF)
*Any documentation of patient disease progression or decline (visit note, H&P, hospital notes)
*Tried and failed therapies

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

Physician signature: ______________________ Date: ______________________

Physician name: (Please print) ______________________

Phone: ______________ Fax: ______________ License #:______________ NPI #: ______________