

Immune Globulin Referral Form

Last 4 SSN#: _____

Date: _____ Patient Name: _____ DOB: _____ Phone: _____ Male Female

Patient Address: _____ Insurance Name & ID#: _____

Referral Contact Name & Number: _____ Insurance Name & ID#: _____

Select Applicable Diagnosis and Include Recent Visit Notes and Diagnosis Specific Supporting Clinical Noted:

Immunology (ICD Codes)

- Common Variable Immunodeficiency (D83.9)** Documented hx recurrent infections, low total pre-treatment IgG level, pre/post pneumo titers within 4-8 wks showing poor polysaccharide vaccine response
- IgG Subclass Deficiency (D80.3)** Documented hx recurrent infections, one or more low pre-treatment IgG subclasses (IgG1, IgG2, IgG3, IgG4), pre/post pneumo titers within 4-8 wks showing poor polysaccharide vaccine response
- Specific Antibody Deficiency (D80.6)** Documented dx and hx recurrent infections, Normal quantitative Ig levels, pre/post pneumo titers within 4-8 wks showing poor polysaccharide vaccine response
- Severe Combined Immunodeficiency (D81.9)** Documented dx confirmed by genetic or molecular testing, pre-treatment low IgG level, very low/absent # T cells
- Agammaglobulinemia (D80.0)** Documented dx confirmed by genetic or molecular testing, pre-treatment low IgG level, very low or absent number T cells
- Nonfamilial Hypogammaglobulinemia (D80.1)** Documented hx recurrent infections, pre-treatment low IgG level (usually secondary or acquired)

Dermatology/Rheumatology (ICD Codes)

- Pemphigus Vulgaris (L10.0)** Dx confirmed by biopsy and pathology report, hx rapidly progressing, extensive or debilitating condition and failed standard treatments (corticosteroids, immunosuppressive agents)
- Dermatomyositis (M33.90)/Polymyositis (M06.9)** Documented dx, evidence of failed first line treatments (corticosteroids or immunosuppressants, testing (elevated muscle enzymes, muscle biopsy, skin biopsy)
- Stiff Persons Syndrome (G25.8)** Documented dx and hx of first line treatments, anti-GAD antibody testing

Neurology (ICD Codes)

- Chronic Inflammatory Demyelinating Polyneuropathy (G61.81)** Documented dx, progressive neurological symptoms, Electromyogram/Nerve Conduction (EMG/NCS), CSF (if available)
- Multifocal Motor Neuropathy (G61.82)** Documented dx & hx, Electromyogram/Nerve Conduction (EMG/NCS)
- Guillain-Barre Syndrome (G61.0)** Documented dx & hx of illness
- Myasthenia Gravis (G70.0/G70.01)** Documented dx & worsening symptoms, + acetylcholine receptor (AChR) abs
- Multiple Sclerosis (G35)** Documented dx of relapsing-remitting MS and previous treatments, diagnostic testing (ex. Neuro exam, MRI, +CSF study)

Transplant (ICD Codes)

- Bone Marrow Transplant/Stem Cell Transplant Recipients (Z94.81/Z94.84)** Documented hx infection, date of Tx, pre-treatment low total IgG level
- Solid Organ Transplant (Z94.____)** Documented dx & hx including indication for IVIG:
 - Pre-transplant: high panel reactive antibody to human leukocyte antigens (HLA) (T86.91)
 - Post-transplant: Graft vs Host Disease (D89.810)
 - Post-transplant: recipients at risk for CMV (T86.0)
 - Post-transplant: treatment for antibody mediated rejection (T86.11)

Other (ICD Codes)

- B-cell Chronic Lymphocytic Leukemia (C91.11)** Documented hx recurrent infections and date of Tx, pre-treatment low IgG level
- _____

Detailed Written Orders:

Height: _____ inches cm **Weight:** _____ lbs kg

Allergies: _____

- IVIG** (pharmacist to brand) **SCIG** (pharmacist to brand)
- Gamunex-C (J1561)** **Hizentra (J1559)**
- Gamagard (J1569)** **Xembify (J1558)**
- Privigen (J1459)** **HyQvia (J1575)**
- Panzyga (J1599)** **Cutaquig (J3590)**
- _____ (other) _____ (other)

Dose: _____

Frequency: _____ **Duration:** _____

Pharmacist to dose

Premedication: Diphenhydramine 25mg PO Acetaminophen 650mg PO

Hydration: _____

Other: _____

Pharmacy OK to Substitute Brand when Insurance Dictates

First Lifetime Dose: Yes: IgA level: _____ N/A:

No: Previous Brands: _____

Date of Last Dose: _____ Next Dose Due: _____

Lab Orders: _____

Fax Lab Results To: _____

Ancillary orders will include:

- Skilled Nursing Visits to administer (IVIG) and/or teach (SCIG) Infusions
- NaCl 0.9% 5-10ml IV before and after infusion for peripheral access and PRN
- Heparin 100 units/ml 3-5ml IV after infusion for Port IV access and PRN
- All infusion supplies necessary to administer the medication
- Anaphylaxis Kit

IV E0781 Pump, A4221 Cath Supplies, A4222 Pump Supplies SQ K0552 Pump, A4221 Cath Supplies, A4222 Pump Supplies

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)
By signing this form & utilizing our services, I am also authorizing ContinuumRx to serve as my prior authorization agent with medical & pharmacy insurance providers.

Physician Signature: _____ Date: _____

Physician Name: (Please print) _____

Phone: _____ Fax: _____ NPI #: _____

Phone Orders Received From: _____ Date/Time: _____

Referral Checklist:

- Patient Demographics
- Copy Insurance Card
- Signed Orders Including Date, Dose, Freq, Duration
- Office/Hospital Visit Notes (within 3-6 months)
- Clinical Supporting Dx
- Pertinent Labs & Testing
- Tried & Failed Therapies