ARJ Infusion SERVICES *Specialty Pharmacy & High-Tech Nursing*

Adult Intravenous Immune Globulin (IVIG) Patient Referral Form

FAX completed form to ARJ (877) 451-8955
Intake Specialist (866) 451-8804
referral@arjinfusion.com
arjinfusion.com/referrals

Patient Name: _____ **Date:** _____

SSN#: _____ DOB: _____ Primary Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Diagnosis: ***SEE REVERSE SIDE FOR MORE ICD-10 CODES***

279.02 Selective IgM Immunodeficiency
☐ D80.4 Selective Deficiency Immunoglobulin M (IgM)

279.04 Congenital Hypogammaglobulinemia
☐ D80.0 Hereditary Hypogammaglobulinemia

279.05 Immunodeficiency with increased IgM
☐ D80.5 Immunodeficiency with increased Immunoglobulin M (IgM)

279.06 Common variable immunodeficiency (CVID)
☐ D83.0 Common variable immunodeficiency w/ predominate abnormalities of B-cell numbers and functions
☐ D83.2 Common variable immunodeficiency with autoantibodies to B or T cells
☐ D83.8 Other common variable immunodeficiency
☐ D83.9 Common variable immunodeficiency, unspecified

358.00 Myasthenia Gravis without exacerbation
☐ G70.00 Myasthenia Gravis without (acute) exacerbation

358.01 Myasthenia Gravis with exacerbation
☐ G70.01 Myasthenia Gravis with (acute) exacerbation

☐ **Other ICD-10:** _____

1 Patient Information: *In order to service your patient and facilitate insurance authorization, please complete the following.*

☐ NKDA Allergies: _____

Ht: _____ in/cm Wt: _____ lbs/kg Male ☐ Female ☐

Is this the first dose: Yes ☐ No ☐

If no, list product: _____

Date of last infusion: _____ Next dose due: _____

Attach documents to FAX *(see below)*

☒ Copy of insurance card
☒ Patient demographics
☒ Labs to include IgA level
☒ H&P
☐ For immune deficiency: Detailed infection history, baseline IgG levels (including subclasses), immune response to vaccinations (including Pneumorax report)

Other: _____

2 Clinical Information: *ARJ policies and protocols to be provided upon request.*

Medication	Dose	Directions	Quantity/Refills
☐ Preferred Product: _____ ☐ No Preference	_____ grams **OR** _____ gm/kg *(rounded to the nearest vial size)* IV every _____ week(s)	Infuse IV per manufacturer guidelines **OR** over _____ hours. Titration rate according to pharmacy protocol.	Dispense: 1 months supply on all selected medications Refill x12 months unless otherwise noted ☐ *Other:* _____

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure

☐ **Premedication take 30 minutes prior to infusion** *(Note: If nothing is checked, no premeds will be given)*

Diphenhydramine: ☐ 25-50 mg po **OR** ☐ 50 mg IV diluted in D5W or NS 50-100mL, infuse over 10-15 mins.

Antihistamine: ☐ Allegra 180 mg po **OR** ☐ Zyrtec 10 mg po

Methylprednisolone: ☐ 125 mg slow IV push over 5 mins. **OR** ☐ _____ mg slow IV push over 5 mins.

Acetaminophen: ☐ 325-650 mg po **OR** ☐ _____ mg po

☐ D5W or NS 500mL - 1L IV over 30 minutes - 1 hour as tolerated daily PRN for hydration and/or headache

☐ Perform lab draws for the following tests as ordered: _____

_____

☒ RN to instruct patient to hydrate pre/post infusion. RN to instruct patient to take Diphenhydramine 25-50 mg po (max dose 400 mg/daily) and Acetaminophen 325-650 mg po (max dose 3000 mg/daily) every 4-6 hours for 24-48 hours as needed to prevent/treat post infusion headache.

Physician to be notified if headache persists or worsens.

Adverse Reaction Orders: *(Dispense 1 dose of each medication below to keep at pt home)*

In the event of an infusion reaction (*ie: fever, chills, backache, headache, rigors*) the following orders will be followed and physician will be notified.

Note: For mild Immune Globulin reactions, patient may be treated and infusion resumed at a slower rate.

STOP IVIG infusion. Infuse D5W or NS at 20 mL/hr to keep line open, may increase to 100-250 mL/hr for hydration. May give the following if stopping infusion does not resolve symptoms:

1.) Diphenhydramine
50 mg IV diluted in D5W or NS 50-100 mL, infused over 10-15 minutes as tolerated.

2.) Methylprednisolone
125 mg (**OR** _____ mg) slow IV push over 5 minutes.

3.) Acetaminophen
325-650 mg (**OR** _____ mg) po at onset of symptoms.

4.) Ondansetron
4 mg slow IV push over 5 minutes

5.) Epinephrine pen by weight for use IM in anaphylactic reaction. EMS/911 will be called if used.

3 Prescriber Information: *By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.*

Physician Name: Dr. Roger Kobayashi Office Contact: Laura

Address: 2808 S. 80th Ave., Suite 210 City: Omaha

State: Nebraska Zip: 68124 Phone: (402) 625-0816 Fax: _____

License #: _____ DEA#: _____ NPI #: _____

_____ Date: _____ _____ Date: _____

Physician Signature Required - Substitution Permitted ***Physician Signature Required - Dispense as Written***

ARJ Infusion SERVICES *Specialty Pharmacy & High-Tech Nursing*

Adult Subcutaneous Immune Globulin (SCIG) Patient Referral Form

FAX completed form to ARJ (877) 451-8955
Intake Specialist (866) 451-8804
referral@arjinfusion.com
arjinfusion.com/referrals

Patient Name: _____ **Date:** _____

SSN#: _____ DOB: _____ Primary Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Diagnosis:

279.02 Selective IgM Immunodeficiency
- ☐ D80.4 Selective Deficiency Immunoglobulin M (IgM)

279.03 Selective IgG Immunodeficiency
- ☐ D80.3 Selective deficiency of immunoglobulin G (IgG) subclasses

279.04 Congenital Hypogammaglobulinemia
- ☐ D80.0 Hereditary Hypogammaglobulinemia

279.05 Immunodeficiency with increased IgM
- ☐ D80.5 Immunodeficiency with increased Immunoglobulin M (IgM)

279.06 Common variable immunodeficiency (CVID)
- ☐ D83.0 Common variable immunodeficiency with predominate abnormalities of B-cell numbers and functions
- ☐ D83.2 Common variable immunodeficiency with autoantibodies to B or T cells

279.06 Common variable immunodeficiency (CVID) *cont.*
- ☐ D83.8 Other common variable immunodeficiency
- ☐ D83.9 Common variable immunodeficiency, unspecified

☐ **Other ICD-10:** ***SEE REVERSE SIDE FOR MORE ICD-10 CODES***

_____

1 Patient Information:

☐ NKDA Allergies: _____

Ht: _____ in/cm Wt: _____ lbs/kg Male ☐ Female ☐

Is this the first dose: Yes ☐ No ☐

If no, list product: _____

Date of last infusion: _____ Next dose due: _____

Attach documents to FAX *(see below)*

- ☒ Copy of insurance card
- ☒ Patient demographics, to include insurance information
- ☒ Labs to include IgA level
- ☒ H&P
- ☒ For Immune deficiency: Detailed infection history, baseline IgG levels (including subclasses), immune response to vaccinations (including report)

Other: _____

2 Clinical Information: *ARJ policies and protocols to be provided upon request.*

Medication	Dose	Directions	Quantity/Refills
☐ Preferred Product: _____ ☐ No Preference	_____ grams **OR** _____ gm per kg (rounded to the nearest vial size) _____ day(s) every week **OR** _____ every _____ week(s)	Infuse per manufacturer guidelines subcutaneously in _____ sites over _____ hours via infusion pump as tolerated.	Dispense: 1 month supply on all selected medications. Refill x12 months unless otherwise noted. ☐ *Other:* _____

Premedication take 30 minutes prior to infusion *(Note: If nothing is checked, no premeds will be given)*
- ☐ Diphenhydramine 25 - 50 mg po x1 dose
- ☐ Acetaminophen 325 - 650 mg po x1 dose
- ☐ Other: _____

Medications to be used as needed:
- ☐ Lidocaine 2.5% cream and Prilocaine 2.5% topically: Apply to needle insertion site prior to access PRN
- ☐ Diphenhydramine 25-50 mg po every 4-6 hours as needed for chills, headache, rash/itching (maximum 400 mg/daily)
- ☐ Acetaminophen 325-650 mg po every 4-6 hours as needed for fever, headache or chills (maximum 3000 mg/daily)

☒ **Skilled Nursing** services to be provided for infusion, assessment and teaching as needed.

Adverse reaction medications: *Dispense 1 dose of each medication below to keep at patient home.*
- ☒ EpiPen® 0.3 mg for greater than 30 kg patient weight IM PRN severe anaphylactic reaction; may repeat one time.
- ☒ Diphenhydramine 25-50 mg po for allergic reaction/ anaphylaxis.

☐ Other Instructions: _____

3 Prescriber Information: *By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.*

Physician Name: Dr. Roger Kobayashi Office Contact: Laura

Address: 2808 S. 80th Ave., Suite 210 City: Omaha

State: Nebraska Zip: 68124 Phone: (402) 625-0816 Fax: _____

License #: _____ DEA#: _____ NPI #: _____

_____ Date: _____ | _____ Date: _____

Physician Signature Required - Substitution Permitted ***Physician Signature Required - Dispense as Written***