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

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

Pediatric Intravenous Immune Globulin (IVIG) Patient Referral Form

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: _____

Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other: _____ Lumen #: _____

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 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 month 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 give 30 minutes prior to infusion. Pharmacist may adjust doses as weight changes.
(Note: If nothing is checked, no premeds will be given)

Diphenhydramine: ☐ 1 mg/kg PO (max 50 mg per dose) **OR** ☐ 25-50 mg PO
☐ 1mg/kg IV (max 50 mg per dose) **OR**
☐ 25-50 mg IV diluted in D5W or NS 50-100 mL, infuse over 10-15 mins.

Acetaminophen: ☐ 15 mg/kg PO (max 650 mg per dose) **OR** ☐ 325-650 mg PO

Methylprednisolone: ☐ 1 mg/kg IV (max 125 mg per dose) slow IV push over 5 minutes or diluted in NS 50-100 mL, infuse over 10-15 minutes.
☐ _____ mg IV (max 125 mg per dose) slow IV push over 5 minutes or diluted in NS 50-100 mL, infuse over 10-15 minutes.

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

☐ Other: _____

☒ RN to instruct patient to hydrate pre/post infusion. For any headaches or other post infusion symptoms the physician will be notified.

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:

☒ **Diphenhydramine**
1 mg/kg IV diluted in D5W or NS 50-100 mL, infused over 10-15 minutes as tolerated (max 50 mg per dose).

☒ **Acetaminophen**
15 mg/kg (**OR** _____ mg) po at onset of symptoms (max 650 mg per dose).

☒ **Methylprednisolone**
1 mg/kg (**OR** _____ mg) slow IV push over 5 minutes (max 125 mg per dose).

☒ **Ondansetron**
0.15 mg/kg slow IV push over 5 minutes (max 4 mg per dose).

☒ **Epinephrine** pen by weight for use IM or SQ in anaphylactic reaction. May repeat one time. 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. ARJ Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.*

Physician Name: _____ Office Contact: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

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

_____ Date: _____ ▌ _____ Date: _____

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

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ICD-10

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279.02 Selective IgM Immunodeficiency

- ☐ D80.4 Selective Deficiency of 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

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

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- ☐ D83.9 Common variable immunodeficiency, unspecified

279.12 Wiskott-Aldrich syndrome

- ☐ D82.0 Wiskott-Aldrich syndrome

279.2 Severe Combined Immunodeficiency

- ☐ D81.0 Severe combined immunodeficiency with reticular dysgenesis
- ☐ D81.1 Severe combined immunodeficiency with low T and B cell numbers
- ☐ D81.2 Severe combined immunodeficiency with low or normal B cell numbers
- ☐ D81.6 Major Histocompatibility complex class I deficiency
- ☐ D81.7 Major Histocompatibility complex class II deficiency
- ☐ D81.89 Other combined immunodeficiency
- ☐ D81.9 combined immunodeficiency, unspecified

340 Multiple Sclerosis

- ☐ G35 Multiple Sclerosis

357.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

- ☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

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☐ Other: _____

_____

_____

_____