ARJ Infusion SERVICES

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

Pediatric Subcutaneous Immune Globulin (SCIG) Order Form

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 **OR** 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 1 mg/kg PO (max 50 mg per dose) **OR** ☐ 25-50 mg PO (max 50 mg per dose)

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

☐ Other: _____

Medications to be used as needed:

Diphenhydramine: ☐ 1 mg/kg PO (max 50 mg per dose) every 4-6 hours as needed **OR** ☐ 25-50 mg PO every 4-6 hours as needed
As needed for chills, headaches, rash/itching

Acetaminophen: ☐ 15 mg/kg PO (max 650 mg per dose) **OR** ☐ 325-650 mg PO every 4-6 hours as needed
As needed for fever, headache, chills

☐ **Lidocaine 2.5% and Prilocaine 2.5%** cream topically: Apply to needle insertion site prior to access, as needed.

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

Adverse reaction medications:

Prescriber to send prescription to retail pharmacy for epinephrine pen by weight for use IM PRN in anaphylactic reaction

☐ 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.
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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Patient Referral Form
ICD-10

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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

☐ Other: _____

_____

_____

_____