DELIVERIT PHARMACY
Infusion & Specialty

Address: 12144 Dairy Ashford Rd. Suite 100,
Sugar Land, TX 77478

T: 832.939.8137 F: 832.939.8128

Immune Globulin Referral Form

Complete Patient Demographic Information in Section Below OR Attach Face Sheet from Patient Chart			
First Name:	*Middle Initial:*	*Last Name:*	
Date of Birth:	*Gender:* ☐ M ☐ F	*SSN:*	
Street Address:	City:	State:	Zip Code:
Home Phone:	*Work Phone:*	*Cell Phone:*	

Complete Patient Insurance Information in Section Below OR Attach Copies of Patient Insurance Card			
Insurance Carrier Name - Primary:	*Name of Insured:*		*Relationship:*
ID#:	*Group #:*		*Insurance Phone:*
Rx Carrier Name - Secondary:	*Rx ID#:*	*Rx Group #:*	*Rx Phone #:*

Complete Drug Therapy Information in Sections Below OR Attach Completed Prescription

☐ IVIg

Dose _____ grams/kg/day X _____ days

or _____ grams/day X _____ days

Directions for administration:

Route of Administration: ☐ IV ☐ SC ☐ IM

# of refills: _____

Ig Product: _____ ☐ Do Not Substitute

Access Device for IV: ☐ Peripheral catheter ☐ Other: _____

Epinephrine:

☐ Patient weight ≥30 kg; inject 0.3mg IM PRN for adverse reaction to IVIG

☐ Patient weight 15-30kg; inject 0.15mg IM PRN for adverse reaction to IVIG

See back of form for additional orders

☐ ICD-10 _____Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

☐ ICD-10 _____Congenital Hypogammaglobulinemia

☐ ICD-10 _____Immunodeficiency with increased IgM

☐ ICD-10 _____Wiskott-Aldrich Syndrome

☐ ICD-10 _____Combined Immunity Deficiency

☐ ICD-10 _____Myasthenia Gravis **without acute exac.**

☐ ICD-10 _____Myasthenia Gravis **with acute exac.**

☐ ICD-10 _____Multiple Sclerosis **relapsing/remitting only**

☐ ICD-10 _____Polyneuropathy Idiopathic, **Progressive**

☐ ICD-10 _____Guillian-Barre Syndrome

☐ ICD-10 _____Multifocal Motor Neuropathy

☐ ICD-10 _____Common Variable Immune Deficiency (CVID)
IgG Level: _____ Date: _____

☐ ICD-10 _____Hypogammaglobulinemia
IgG Level: _____ Date: _____

☐ Other: _____
ICD-10 Code: _____

Allergies: ___	*Weight:* pounds
Current Therapies/Medications: ___	

☐ Infused at MDO ☐ Infused at home: Set up of Skilled nursing visits required

Complete Prescriber Information in Section Below NOT Included on Attached Prescription

MD First Name:			
UPIN:	*MD Last Name:*		*DEA #:*
Office Address: / *State License #:*	*NPI:*		
Office Phone:	City:	State:	Zip Code:
Office Contact Name:	*Office Fax:*	*Office E-mail:*	

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS

☐ *I authorize DeliverIt Pharmacy Infusion & Specialty to initiate a Prior Authorization on my behalf.*

Dr: ***NO Substitution Permitted***	**DATE**
Dr: ***Substitution Permitted***	**DATE**