Referral Status:			MRN:
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Intravenous Immune Globulin (IVIG) Unspecified Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:				Patient's Phone:			
Patient Name:				Address:			
Date of Birth:				City, State, Zip:			
Height in inches:	Weight: LB or KG			Gender:	Allergies: ☐	See list ☐	NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	D80._____ - Hypogammaglobulinemia	☐	D83._____ - Common variable immune deficiency
☐	M33.2_____ - Polymyositis	☐	M33.9_____ - Dermatopolymyositis
☐	G61.81 - CIDP	☐	G61.0 - Guillain Barre syndrome
☐	G70.01 - Myasthenia Gravis with acute exacerbation	☐	G70.00 - Myasthenia Gravis without acute exacerbation
☐	D69.3 - ITP	☐	_____- Other:_____

REQUESTED DOCUMENTATION:		PREVIOUS AMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	REQUIRED WASHOUT FROM PREVIOUS THERAPY:	**IF ORDER CHANGE:**
2	H&P including tried and failed therapies		☐ **Continue current order until insurance approved**
3	Full medication list		

[INTERNAL USE ONLY] PHARMACIST CALCULATED DOSE AND INFUSION TIME REVIEW: (IF APPLICABLE)

	Pharmacist initials and date of review:

MEDICATION ORDERS:

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV

Diphenhydramine	☐ 25mg	☐ 50mg				
Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:			
Famotidine	☐ 20mg	☐ 40mg				
Other:	☐					
Prehydration with NS	☐ 250ml	☐ 500ml	☐ 1000ml			
Posthydration with NS	☐ 250ml	☐ 500ml	☐ 1000ml			

Pre and post infusion hydration will be given at 500ml/hour unless stated otherwise here: _____ (maximum 1L/hour)

PO

Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg
Famotidine	☐ 20mg	☐ 40mg		
Diphenhydramine	☐ 25mg	☐ 50mg		
Fexofenadine	☐ 60mg	☐ 180mg		
Cetirizine	☐ 10mg			
Loratadine	☐ 10mg			
Other:	☐			

IVIG DOSE:

☐ _____gm/kg/day

☐ _____gm/day

Dosing will be rounded to the nearest 5gm for adults and nearest 1gm for pediatric patients to minimize drug waste

FREQUENCY:

☐ One time dose

☐ Daily x _____ days ☐ Once ☐ Every ___ weeks

☐ Once every ____ weeks

☐ Specific Brand of IVIG required:_____

SPECIAL/LAB ORDERS:

☐ _____

_____

IVIG product brand will be based on supply and availability of product, unless specified. Infusion rate protocol: will be based on consideration of age, medical history, risk of renal failure, and patient tolerance. Actual Body Weight will be used to dose IVIG unless otherwise specified.

****Dose will be held if patient temperature is > 101.5°F & MD will be notified****

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	

ACCURX
INFUSION CENTER
A PALMETTO INFUSION COMPANY

Checklist for referrals to AccuRX Infusion:

Fax referral to 1.866.990.3192

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com

02/08/2023