Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

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

Immunoglobulin Subcutaneous Standard 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 ☐ NDKA

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

- ☐ D80.1____ - Hypogammaglobulinemia
- ☐ D80.2____ - Select IG Deficiency
- ☐ D83._____ - CVID
- ☐ ________ - Other:

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	IG levels
6	

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
	NEXT INJECTION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: DO NOT ADMINISTER SUBCUTANEOUS IG IF PATIENT'S TEMPERATURE IS GREATER THAN OR EQUAL TO 101.5ºF ORALLY AND NOTIFY MD.

MEDICATION:

- ☐ Gammagard 10%
- ☐ Gamunex 10%
- ☐ Gammaked 10%
- ☐ Hizentra 20%
- ☐ Xembify 20%
- ☐ Other:_______________________________

NOTE: For HyQvia Plan of Treatment please see our website for medication specific document.

DOSE:

☑ _______ Grams ***subcutaneous administration*** via syringe pump to infuse per protocol

FREQUENCY:

- ☐ Every _____ days
- ☐ Every _____ weeks

DURATION:

- ☐ One time dose
- ☐ _____ weeks
- ☐ _____ months

SPECIAL/LAB ORDERS:

☐ ____

____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

N/A

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion 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	