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

Rev 4.28.25

Immunoglobulin Subcutaneous Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Patient Name:							
Patient's Phone:			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	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	IG levels		☐ **Continue current order until insurance approved**
6			

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

MEDICATION ORDERS:

NOTE: DO NOT ADMINISTER SUBCUTANEOUS IG IF PATIENT'S TEMPERATURE IS GREATER THAN OR EQUAL TO 101.5°F 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.

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	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- ☐ **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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.palmettoinfusion.com