1935 W. State Street STE 103
Garland, TX 75042
Ph: 972-372-7987
Fx: 972-787-1492

IVIG INFUSION REFERRAL FORM

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Patient Height: __________inches; Weight __________kg

DIAGNOSIS AND ICD 10 CODE			
☐ Immunodeficiency w/ antibody subclass	ICD 10 Code: ____________	☐ Combined ID	ICD 10 Code: ____________
		☐ Common Variable ID	ICD 10 Code: ____________
☐ Severe Combined ID	ICD 10 Code: ____________	☐ Other_______________	ICD 10 Code: ____________

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ **IgG level and Ig subclass** lab results
☐ Patient demographics and Insurance Card	☐ First Dose to begin by _________________
☐ Clinical/Progress notes **w/ documented infections**	☐ Last given dose: __________________
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	PA Guidance: Diagnosis of primary immunodeficiency w/ clinically significant functional humoral deficiency. Documented failure to produce antibodies to specific antigens OR a history of ***significant*** recurrent infections. NOTE: IVIG may NOT be approved for Isolated IgA; IgE; IgM; IgG4 deficiency.

ORDERS	
Dosing	☐ IVIG ____mg/kg IV every ____weeks ☐ Tylenol 650mg PO 30 min prior to infusion ☐ SCIG ____mg/kg IV every ____weeks ☐ Benadryl 50mg ☐ PO ☐ IVP 30 min prior ☐ Emla cream- topically 30 min prior ☐ Other_____________________________ ☐ NaCl 0.9% ________ml IV ☐ Pre and/or ☐Post IVIG
Infusion orders	■ RN to start, pause, or discontinue peripheral or central venus access device as needed ■ Flush IV line with 10-20ml saline before and after each medication dose or as needed ■ Flush PORT or Central Line with 500u/5ml Heparin as FINAL flush or as needed ■ Dispense DME pump with all necessary supplies for home infusion
Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 1L 0.9% NS)	
Refills:	☐ X 1 year ☐ _____ doses

PRESCRIBER INFORMATION		
Prescriber Name:		NPI #:
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

By signing, I authorize Texas Infusion to act as an agent to initiate and execute the insurance authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time in writing via email to pharmacy@texasinfusion.com

PLEASE FAX SIGNED FORM TO 972-787-1492

UPDATED: 1-2-2023