IVIG Infusion

OptiMed
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Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

Patient Information

Name: _____ **DOB:** _____ ☐M ☐F

Address: _____

Phone: _____ **2nd Phone:** _____ **SSN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis:
☐D80.0 Hereditary hypogammaglobinemia
☐D81.89 Combined immunodeficiencies
☐D82.0 Wiskott-Aldrich syndrome
☐D83.8 Common variable immunodeficiency
☐Other: _____ ICD-10 Code: _____
☐G61.0 Acute Infective Polyneuritis (Guillain-Barre Syndrome)
☐G61.81 Chronic Inflammatory Demyelinating Polyneuritis (CIDP)
☐G61.9 Inflammatory Polyneuropathy, unspecified (MMN)

IgA deficiency: ☐Yes ☐No

Weight: _____ ☐lb ☐kg **Height:** _____ ☐in **IV access:** ☐PIV ☐PICC ☐Port ☐Other: _____

Allergies: _____ **Latex allergy?** ☐Yes ☐No

Will this be the patient's first dose? ☐Yes ☐No, date of last dose: _____ ; Product _____ ; Dose _____

Prior treatments & reason for discontinuation: _____

_____

Referring provider's preferred site of care*: ☐OptiMed Infusion Center ☐Home Infusion* ☐OptiMed to determine site of care
*Site of care preference is subject to payer limitations, clinical appropriateness, and the availability of servicing providers.

Additional Notes: _____

_____

Prescription Information

IVIG Product: ☐Pharmacist to determine based on availability and coverage
☐Specific product required: _____

IG Dosing Regimen	Quantity
_____ g/day for _____ day(s) every _____ weeks	_____ doses (infusions)

Based on the clinical judgement of the pharmacist, doses may be rounded up or down by no more than 10% unless checked here: ☐

Rate of Administration: ☐Pharmacist to determine based on manufacturer guidelines
☐Custom _____

Premedication(s): ☐Acetaminophen 325-650mg PO 15-30 minutes prior to infusion
☐Diphenhydramine 25-50mg PO 15-30 minutes prior to infusion
☐Other premedication(s) _____

PRN Medication(s): ☐Acetaminophen 325-650mg PO Q4 hours PRN ☐Diphenhydramine 50mg IV x1 dose PRN
☐Methylprednisolone 125mg IV x1 dose PRN ☐Other PRN medication(s): _____

Laboratory orders (subject to availability) _____

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.

Signature _____ **Date**_____

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CLEAR FORM