

IVIG NEUROLOGY REFERRAL FORM

3070 McCann Farm Drive | Suite 101
Garnet Valley, PA 19060

1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

Today's Date

CURRENT PATIENT
 NEW PATIENT

FEB 2018

Patient Name _____ SS# _____ DOB _____ Male Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at Home Work OR Patient will pick up at Physician Office Local Pharmacy Phone _____
Medical History: Cardiac Disease Diabetes Renal Dysfunction IgA Deficient
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION
_____	_____	_____	_____
_____	_____	_____	_____

REFERRAL SOURCE INFORMATION			
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____

Insured's Name _____ Relation to Patient _____
Eligible for Medicare Yes No If yes, Medicare# _____ Prescription Card Yes No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Diagnosis Code G61.0 Guillain-Barre Syndrome G70.80 Lambert-Eaton Syndrome, unspecified
 G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) M36.0 Dermatomyositis
 G61.9 Inflammatory Polyneuropathy, unspecified G25.82 Stiff-Person Syndrome
 G70.01 Myasthenia Gravis with (Acute) Exacerbation G35 Multiple Sclerosis (MS)
 M33.20 Polymyositis, organ involvement unspecified ICD-10: _____ DX: _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

Is this the first dose? Yes No If no:
List product _____
Date of last infusion _____
Next dose due _____

ADMINISTER IVIG USING INFUSION PUMP:

2 grams/kg over _____ days, as a loading dose, then _____ grams every _____ wk(s) for _____ cycle(s)
 _____ gm/kg or _____ grams every _____ wk(s) for _____ cycle(s)
 Other _____

PRE-MEDICATIONS

Diphenhydramine (Benadryl) 25-50 mg orally before infusion
 Acetaminophen (Tylenol) 325-650 mg orally before infusion
 Other _____

ADVERSE/ANAPHYLACTIC REACTIONS: PER ELWYN SPECIALTY CARE PROTOCOL

Adults or Children greater than 66 pounds or 30 kg:

- For mild reaction: give Diphenhydramine 50 mg orally, IM or IV and decrease the rate of infusion.
- For moderate reaction: stop infusion, give Diphenhydramine 50mg, orally, IM or IV and contact physician
- For Severe reaction w/breathing problem: stop infusion, call 911, give Epinephrine 0.3mg/0.3ml subcutaneously, Diphenhydramine 50 mg IV or IM. Begin NSS 500ml IV at a rate of 100-150ml/hr and contact physician.

Note: **Dosage adjustment necessary for children less than 30kg or 66 pounds:** Diphenhydramine 1.25mg/kg orally, IM or IV with a maximum of 50mg. If Epinephrine is needed 0.15mg/0.15ml 1:1000 subcutaneously

Nursing: Start PIV as required for administration and nurse to administer infusion in home.

Access: Peripheral PICC Port Other _____

Flushing: Elwyn Specialty Care Protocol (Heparin, 0.9% NaCl, D5W)

Labs _____

By signing this form and utilizing our services, you are authorizing Elwyn Specialty Care and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Please fax completed referral form to **Elwyn Specialty Care** at **610-545-6030** Visit **WWW.ELWYNSPECIALTYCARE.COM** for online fillable forms.