Elwyn SPECIALTY CARE
A BIOMATRIX RxRx Company

# ITP Referral Form

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FEB 2018

Patient Name _____
Address: _____
Apt / Suite # _____
City: _____ State: _____ Zip: _____
Date of Birth: ___/___/___
Height: _____ Weight: _____
Phone: _____ 2nd Phone: _____

**Patient Records (Please Attach and Fax):**
1. Insurance Card(s) and Demographic Information
2. Recent Clinical Assessment Note or H&P
3. Current Medication List

Allergies: _____

PMH: ☐ IGA Deficiency ☐ Cardiac Disease ☐ Diabetes ☐ Renal Dysfunction

**Statement of Medical Necessity - Primary Diagnosis**

☐ Transient Neonatal Thrombocytopenia P61.0
☐ Idiopathic Thrombocytopenia Purpura (ITP) D69.3
☐ Maternal care for other Rh isoimmunization, unspecified trimester, not applicable or unspecified O36.0990
☐ Hemochromatosis, unspecified E83.119

Current Gestational Age: _____ EDC: _____
Gravida: _____ Para: _____

**For NAIT:**
Has HPA-1a testing been completed? ☐Yes ☐No
Results confirm NAIT? ☐Yes ☐No

**For ITP:**
Current Platelet Count: _____

## PRESCRIPTION

Is this the first dose? ☐ Yes ☐ No If no, date first dose given: _____ Next dose due: _____
**Administer IVIG** **Product:** ☐ Pharmacist to determine (or) ☐ Formulation _____

**Dose:** (please select one and provide coplete information)
☐ **2 g/kg over _____ days, repeat course every _____ week(s) for _____ cycle(s)**
☐ **_____ mg/kg or _____ g every _____ week(s) for _____ cycle(s)**
☐ **Other Regimen:** _____
**Infusion Rate per manufacturer recommendations unless otherwise noted:** _____

**Access:** ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____
**Flushing:** Elwyn Specialty Care Protocal (Heparin 100 unit/mL, 0.9% NaCl 500 mL bag)
**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

**Pre-treatment:**
☐ Diphenhydramine (Benadryl) 25-50 mg orally before infusion
☐ Acetaminophen (Tylenol) 325-650 mg orally before infusion
☐ Other: _____

**Labs:**
☐ BUN and Serum Creatinine; Fax Results ☐ Prior to first infusion ☐ After _____ infusion
☐ Other: _____ Fax Results ☐ Prior to first infusion ☐ After _____ infusion

### MONITOR

**Observe:** Vital signs prior to infusion. Blood pressure and pulse every 30 minutes until stable infusion rate, then every hour.

**Watch for:** Signs of fluid overload, cardiovascular symptoms, allergic reactions, skin rash, fever, and moderate to severe headache.

**Call/Page MD:** For adverse events, stop the infusion. Can restart the infusion at the same or lower rate pending physician's approval or if symptons subside.

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_____

Prescriber's Name _____ Office Contact _____
Street Address _____ Suite # _____City_____ State _____ Zip _____
Tel _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____
Physicians Signature: _____ Date: _____

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