Elwyn SPECIALTY CARE
A BIOMATRIX SpRx Company

FEB 2018

SUBCUTANEOUS IMMUNE GLOBULIN REFERRAL FORM

3070 McCann Farm Drive | Suite 101
Garnet Valley, PA 19060
TEL: 610-545-6035 | FAX: 610-545-6034
Toll Free: 844-691-5089

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

Patient Name ______ SS# ______ DOB ______
Height ______ Weight ______ Address ______ Apt # ______
☐ Male ☐ Female City ______ State ______ Zip ______
Daytime Tel ______ Cell ______ Email ______
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed ______
Allergies ______ Comorbidities ______
Current Medications (if necessary, please fax a complete list) ______

Insurance Carrier - Primary ______ Name of Insured ______
Relationship ______ ID # ______ Group # ______ Insurance Phone ______
Rx Carrier - Secondary ______ Rx ID # ______ Rx Group # ______ RX Phone ______

Prescriber's Name ______ Office Contact ______
Street Address ______ Suite# ______ City ______ State ______ Zip ______
Tel ______ Fax ______ Email ______
License# ______ NPI# ______ UPIN# ______ DEA# ______

Diagnosis ☐ ICD-10:______ DX:______ ☐ ICD-10:______ DX:______
☐ HTN ☐ Renal Dysfunction ☐ Thromboembolic event ☐ Other: ______

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PRESCRIPTION: ______(medication) ______ grams ______day(s) per week for ______ weeks via pump
TOTAL INFUSION VOLUME is: ______ Total # infusion sites: ______ duration of Infusion: ______min
DISPENSE a 4-week supply = ______mL with ______refills
Dose may be rounded to next vial size to minimize product wastage.

PRE-TREATMENT PROPHYLAXIS MEDICATION ORDERS
Administer 30-60 minutes prior to infusion:
☐ Acetaminophen 650 mg PO ☐ Diphenhydramine 25-50 mg PO ☐ Diphenhydramine 25-50 mg IV Push
☐ Hydrocortisone 100 mg/2 mL slow IV push ☐ Lidocaine/ Prilocaine Topically PRN ☐ Other______

ANAPHYLAXIS ORDERS

ADULT (> 30 kg)
☐ Epinephrine 1:1000 (0.3 mg) Autoinjector
Administer IM or Sub-Q may repeat PRN
☐ Diphenhydramine: 50 mg IM/IV push, prn
☐ Other ______

PEDIATRIC (15-30 kg)
☐ Epinephrine 1:1000-JR (0.15 mg) Autoinjector
Administer IM or Sub-Q May repeat PRN
☐ Diphenhydramine: 1-2 mg/kg (up to 50 mg) IM/IV push, PRN
☐ Other: ______

SUBSTITUTIONS

PRODUCT SUBSTITUTION PERMITTED

______
signature date

DISPENSE AS WRITTEN

______
signature date

By signing this form and utilizing our services, you are authorizing Elwyn Specialty Care and it's 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 **610-545-6034** Visit **www.ELWYNSPECIALTYCARE.com** for online fillable forms.

© 2018 UpTrend Consulting & Creative LLC - All rights reserved.