IVIG Referral Form

Provider Order Form *rev. 1/2/2025*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☑ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

Primary Immunodeficiency
- ☐ D80.0 Hereditary hypogammaglobulinemia
- ☐ D80.1 Nonfamilial hypogammaglobulinemia
- ☐ D80.3 Selective deficiency of immunoglobulin G [lgG] subclasses
- ☐ D83.9 Common variable immunodeficiency, unspecified
- ☐ D89.89 Other disorder involving the immune mechanism, NEC

Neurology/Neuromuscular
- ☐ G61.81 Chronic inflammatory demyelinating polyneuritis
- ☐ G61.82 Multifocal motor neuropathy

Inflammatory Myopathies
- ☑ M33.00 Juvenile dermatomyositis, organ involvement unspecified
- ☐ M33.10 Other dermatomyositis, organ involvement unspecified
- ☐ M33.13 Other dermatomyositis without myopathy
- ☐ M33.20 Polymyositis, organ involvement unspecified
- ☐ M33.22 Polymyositis with myopathy
- ☐ M33.90 Dermatopolymyositis, unsp, organ involvement unspecified
- ☐ M33.91 Dermatopolymyositis, unsp with respiratory involvement
- ☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications
- ☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
- ☐ Cetirizine (Zyrtec) 10mgPO
- ☐ Loratadine (Claritin) 10mgPO
- ☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
- ☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
- ☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: CBC w/ diff, CMP, Serum Creatinine
Serum IgG Level
Based on Certain Conditions: Platelet Count (ITP)
CK (dermatomyositis)
☐ Other: _____

IVIG Orders (Select one):

No Brand Preference:
- ☐ Immune Globulin Solution (5%)
- ☐ Immune Globulin Solution (10%)

If Brand Preference:
- ☐ Gamunex (10%)
- ☐ Gammagard Liquid (10%)
- ☐ Gammagard S-D (5%)
- ☐ Octagam (5%)
- ☐ Octagam (10%)
- ☐ Privigen (10%)

Dosing:
- ☐ _____ Grams/kg or _____ grams divided equally over _____ days every _____ weeks
- ☐ _____ mg/kg or _____ milligrams divided equally over _____ days every _____ weeks
- ☐ Other: _____

*Dose will be rounded to the nearest 5g vial size. To prohibit dose rounding, check here ☐

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

☐ **Refills:** ☐ zero ☐ 6 months ☐ 12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print) *Provider Signature* *Date*

E: Referrals@americaninfusioncare.com
Americaninfusioncare.com

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): **F: 469.305.2361 P: 972.865.4454**