IMMUNE GLOBULIN REFERRAL FORM

CureStat Rx
Home Infusion and Specialty Pharmacy

Phone: (888)963-6544 Fax: (858)281-0045

PATIENT INFORMATION ☐ Deliver Here

Patient Name: _____
DOB: _____ Gender: ☐ Male ☐ Female
Address: _____
City_____ State_____ Zip: _____
Primary Phone: _____ SSN: _____
Caregiver Name: _____
Alternate Phone: _____
Please fax a copy of front and back of the insurance card(s).

PRESCRIBER INFORMATION ☐ Deliver Here

Prescriber Name: _____
State License #: _____ DEA #: _____
NPI #: _____
Address: _____
City_____ State_____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

Clinical Information (Please fax pertinent lab information)

Diagnosis: ☐ D80.0 (Congenital Hypogammaglobulinemia) ☐ D80.1 (Nonfamilial hypogammaglobulinemia) ☐ D80.6 Selective Antibody Deficiency
☐ D81.9 (SCID, unspecified) ☐ D83.9 (CVID) ☐ G35 (Multiple Sclerosis) ☐ G61.0 (Guillain-Barré Syndrome) ☐ G61.81 (CIDP) ☐ G61.82 (MMN)
☐ G70.00 (MG without acute exacerbation) ☐ G70.01 (MG with acute exacerbation) ☐ M33.20 (Polymyositis) ☐ M33.90 (Dermatomyositis)
Other: _____ Diagnosis date: _____
Wt: _____ ☐ Kg ☐ lbs Ht: _____ ☐ cm ☐ in Allergies: ☐ NKDA ☐ Other: _____
IgA deficiency: ☐ Yes ☐ No IgA level: _____mg/dL Date: _____ IgG trough: _____mg/dL Date: _____
First time receiving Immune Globulin? ☐ Yes ☐ No If No, previous product used: _____
Date of last infusion: _____ Date of next infusion: _____
Comorbidities: _____
Concomitant Medications: _____

Prescription

Select one Immune Globulin Product:

☐ Cuvitru 20%	☐ Gammaked10%	☐ Gammagard S/D 10%	☐Gamunex-C 10%	☐Octagam 10%
☐ Flebogamma 5%	☐ Gammagard Liq 10%	☐ Gamastan (IM route)	☐Hizentra 20%	☐Privigen 10%
☐ Flebogamma 10%	☐ Gammagard S/D 5%	☐ Gammaplex 5%	☐HyQvia 10%	
☐Other: _____		☐ Gammaplex 10%	☐Octagam 5%	

Therapy Regimen	Dose: _____ g/kg Total Dose: _____ grams Daily for _____ days every _____ weeks Administration rate: _____ mL/kg/hr Qty to dispense: _____ Refills: _____		
Pre-Medication Protocol	☐ Diphenhydramine _____mg 30 min before infusion ☐ PO ☐ IVP ☐ Acetaminophen _____mg PO 30 min before infusion ☐ Other: _____ ☐ Other: _____	☐Hydration Infuse _____ mL _____ solution ☐Prior to ☐Following ☐Solu-Cortef _____ mg slow IVP ☐Solu-Medrol _____ mg slow IVP ☐ Pre ☐ Halfway ☐ Upon completion	
Flushing Protocol	Normal Saline _____mL Pre-medication _____mL Post medication	Heparin _____Units/mL Pre-medication _____Units/mL Post medication	
Anaphylaxis Orders and Medications	Orders: 1. Stop Infusion 2. Call 911 and prescribing physician 3. Administer medications below as per protocol		_____ Refills
	Diphenhydramine 50 mg/mL	☐ Administer 12.5 mg/0.25 mL (weight<15kg) by slow IV push or IM ☐ Administer 25 mg/0.5 mL (weight 15-30 kg) by slow IV push or IM ☐ Administer 50 mg/mL (weight >30 kg) by slow IV push or IM	Qty: _____
	Epinephrine 1 mg/mL	☐ Administer ____ mg (0.01 mg/kg or 0.01mL/kg) (weight<15kg) IM ☐ Administer 0.15 mg/0.15 mL (weight 15-30 kg) IM ☐ Administer 0.3 mg/0.3mL (weight >30 kg) IM	Qty: _____

☐ Product substitution permitted ☐ Dispense as written

Prescriber's Signature: _____ Date: _____