CURBSIDE INFUSION VENTURE

Immune Globulin Neurology Referral Form

of Pages Faxed:_____
Fax Referral To: 877-428-1627
Phone: 877-428-7248

Date Required:_____ Ship To: ☐ Home ☐ Office ☐ Other:_____

PATIENT INFORMATION

Patient Name:_____
Address:_____
City, State, Zip:_____
Home Phone:_____
Cell Phone:_____
Alternate Phone:_____
Date of Birth:_____

PRESCRIBER INFORMATION

Prescriber Name:_____
Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____
DEA #:_____ NPI #:_____
Contact Person:_____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance:_____ ID:_____ Group:_____
Secondary Insurance:_____ ID:_____ Group:_____
Prescription Card:_____ ID:_____ BIN:_____ PCN:_____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

Neurological:

☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ M33.10 Dermatomyositis
☐ G61.0 Guillian-Barré Syndrome
☐ G70.80 Lambert-Eaton Syndrome
☐ G62.89 Multifocal Motor Neuropathy (MMN)
☐ G35 Multiple Sclerosis (Relapsing/Remitting)
☐ G70.01 Myasthenia Gravis w/Acute Exacerbation
☐ G62.9 Polyneuropathy, Unspecified
☐ M33.22 Polymyositis
☐ G25.82 Stiff-Person Syndrome
☐ Other:_____

PATIENT EVALUATION

Has patient previously received IVIG? ☐ Yes ☐ No
Patient Weight:_____ ☐ kg ☐ lbs Height:_____ ☐ cm ☐ in
Allergies:_____
Line Access: ☐ Peripheral ☐ PICC ☐ Port
Delivery Method: ☐ Infusion Pump ☐ Other:_____
Therapy Start Date:_____ Therapy End Date:_____
Nursing Coordination:

☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No

☐ Home health nursing coordination not necessary. Reason:
- ☐ MD office to administer to patient
- ☐ Home health nursing already coordinated

☐ Patient demographics, including insurance information.
☐ Labs – Antibody testing results, most recent BUN/SCr and IgA level
☐ H&P
☐ Medications/Therapies tried and failed
☐ Baseline assessment, including detailed patient symptoms
☐ Please attach original prescription orders

As Appropriate:
- ☐ Nerve Conduction Study results, including velocities
- ☐ Biopsy results
- ☐ Electromyography (EMG) results
- ☐ CSF studies

☐ Other:_____

PRESCRIPTION INFORMATION

Immune Globulin Prescription:

Loading Dose: IVIG _____ gm/kg given over _____ day(s) OR _____ gm daily for _____ day(s)

Maintenance: IVIG _____ gm/kg given over _____ day(s) OR _____ gm daily for _____ day(s)

☐ Repeat course every _____ week(s) x _____ course(s)
☐ Refill x _____ (length of time)

Subcutaneous Prescription:

IG _____ gm monthly OR _____ gm every _____ weeks.
Administer SCIG using _____ sites at a time. Repeat _____ week(s). Refill x 1yr.

☐ OK to round to the nearest vial size
☐ +/- 4 days to allow scheduling flexibility

Multiple doses will be administered on consecutive days unless ordered otherwise.
☐ non-consecutive days only

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol

☐ NaCl 0.9% 5ml
☐ NaCl 0.9% 10ml
☐ Heparin 10 units/ml
☐ Heparin 100 units/ml
☐ 250ml 0.9% NaCl for hydration
☐ Other:_____

Pre-Medications & Other Medications

☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol
☐ Acetaminophen _____ mg PO prior to infusion
☐ Diphenhydramine _____ mg PO

Prescriber Signature:_____ **Date:**_____