REALO Rx SPECIALTY CARE PHARMACY

Immune Globulin Referral Form

Phone: 844-814-1943 • Fax: 844-814-1944
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Demographics *(Demographic sheet may be faxed)*

Patient Name: ______________________

Address: ______________________

City: ____________ State: ________ Zip: ________

Date of Birth: ____________ Sex ☐ Male ☐ Female

Phone: (home) ______________________

Phone (cell) ______________________

HT: ____________ WT: ____________

Allergies: ______________________

Insurance Information

(Please attach copy of front and back insurrance card)

Physician Orders *(Please check the following)*

☐ IV ☐ SC

☐ Pharmacist to determine appropriate product based on clinical risk assessment, insurance, and availability **OR**

☐ Preferred Brand Name: ______________________

Has the patient received IVIg previously? ☐ Yes ☐ No

Date of last dose: ______________________

Anticipated start date: ______________________

Infusion Regimen

Dose ____________ grams / kg / day x ________ days

or ____________ grams / day x ________ days.

Interval (frequency of therapy): ______________________

# of refills: ________

May adjust infusion schedule within +/- 7 days if nursing or patient need arises (with payer approval)

Infusion Rate: ______________________

☐ Benadryl ________ mg ☐ PO ☐ IV ____________

☐ Tylenol ________ mg ☐ PO ☐ IV ____________

☐ IV Steroids: ____________ Dose: ________ Pre/Post

☐ IV Hydration: ____________ mls NaCl Pre/Post

☐ Other Premeds: ______________________

☐ Anaphylaxis Kit per protocol

☐ 0.9% NaCl Flushes 5-10 ml pre/post infusion and PRN

☐ Heparin 100 units/ml 5 ml post infusion and PRN

☐ Skilled Nursing visits as required

☐ Standard supplies as needed

Diagnosis *(Please check one of the following)*

☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

☐ G25.82 Stiff Person Syndrome

☐ G70.00 Myasthenia Gravis **without acute exac.**

☐ G70.01 Myasthenia Gravis **with acute exac.**

☐ G35 Multiple Sclerosis **relapsing/remiting only**

☐ G60.3 Polyneuropathy Idiopathic, **Progressive**

☐ G61.0 Guillian- Barre Syndrome (acute infective polyneuritis)

☐ M33.2 Polymyositis

☐ M33.1 Dermatomyositis

☐ G61.82 Multifocal Motor Neuropathy

☐ D83.9 Common Variable Immune Deficiency (CVID)

IgG Level: ____________ Date: ____________

☐ D80.1 Hypogammaglobulinemia, nonfamilial

IgG Level: ____________ Date: ____________

☐ D69.6 Thrombocytopenia (ITP)

Plt Count ____________ Date: ____________

☐ P61.0 Transient Neonatal Thrombocytopenia

☐ Other: ______________________

ICD-10 Code: ______________________

Prescribing Physician

Name: ______________________

Address (please include facility name):

____

____

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____

Phone: ____________ Fax: ____________

Specialty: ______________________

DEA #: ____________ NPI#: ____________

I have read this entire form and verify to its accuracy.

I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke tthis designation at any time by providing written notice to Realo Specialty Care Pharmacy.

Physician Signature: ______________________

Date: ____________

Please fax completed referral form and patient's insurance card(s) to (844) 814-1944.
Or call Realo Specialty Pharmacy for assistance at (844) 814-1943.