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: _____

Physician Orders *(Please check the following)*

☐ IV-Peripheral ☐ IV-Port ☐ 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

Loading Dose _____

Maintenance Dose _____

# 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: _____

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

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

■ Anaphylaxis Kit per protocol

■ Skilled Nursing visits as required

■ Standard supplies as needed

Referral Checklist - Please send the following:

☐ Patient Face Sheet / Demographics
☐ Insurance Cards (Front and Back)
☐ Provider Progress Notes
☐ Labs (If Appropriate)

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
☐ M33.2 Polymyositis
☐ M33.1 Dermatomyositis
☐ G61.82 Multifocal Motor Neuropathy
☐ D83.9 Common Variable Immune Deficiency (CVID)
☐ D80.1 Hypogammaglobulinemia, nonfamilial
☐ Other: _____
ICD-10 Code: _____

Prescribing Physician

Physician Name: _____

Referral Contact: _____

Address (please include facility name):

_____

_____

_____

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 or email completed referral form and additional info on checklist.
Call Realo Specialty Care Pharmacy for assistance at (844) 814-1943.