IVIG

Referral Phone: 800-622-9321
Referral Fax: 614-367-1684

DECILLION HEALTHCARE

Demographics

Last Name:	First Name:	Male/Female:	
Home Address:	City:	State:	Zip:
DOB:	Height:	Weight:	Allergies:
Phone (H):	Phone (C):	Phone (W):	
Email: _____ SSN #: _____			

**Complete and Attach Copies of card*

Insurance

Primary Insurance:	City:	State:	Phone:
Card Holder Name:	ID #:	Group #:	
Employer:	Prescription Card:	City:	State:	Phone:

Medical Necessity

Statement of Medical Necessity **Date:**

Diagnosis: _____ICD-9 Code:_____

Diabetic: ___Y ___N

Has patient received IVIG previously? ___Y ___N **If Yes, please list product:** _____

If NO, can first dose be given in home? ___Y ___N Date of last infusion: _____

Baseline lab values (if available, fax copy to Decillion Healthcare). Dates of values: _____

BUN_____ SCr_____ IgA_____ Serum Viscosity_____LFTs_____

Prescription

Immune Globulin Product: _____ ☐ Do Not Substitute

Refills: _____ times (as allowed by the state or pay or requirements)

Administer _____ mg/kg (+ or - 10%) OR _____ gms IV every _____ days OR Other Regimen: _____

Administration Rate: Follow manufacturer guidelines OR Other: _____

Pre-Medication:_____

☐ EMLA®, ElaMax® 4%, Lidocaine 4% (topical cream to be applied topically to site for venous accessing prn)

Provide needles, syringes, VAD supplies & other ancillary supplies needed for infusion

Delivery Method: Gravity Vascular Access Device: ☐ Peripheral Catheter ☐ Other (describe/# of lumens):_____

Flush Orders: ☐ Normal Saline 1-50 ml pre or post infusion prn ☐ D5W 1-50 ml pre or post infusion prn

☐ Heparin 100 units per ml 1-5 ml post infusion prn ☐ Heparin 10 units per ml 1-5 ml post infusion prn

Adverse Reaction Medications to be maintained in the patient's home & administered as necessary:

Diphenhydramine 25-50 mg PO or IV prn allergic reaction

Epinephrine 1:1000 Subcut IM prn severe allergic reaction:

Adults: 0.02 mg per kg up to 0.5 ml Pediatrics greater than 10 lbs: 0.01 mg per kg up to 0.3 ml

Decillion Nursing Services Requested: ___Y ___N

☐ Skilled nursing visit to establish venous access, patient education related to therapy & disease state, administer medication as prescribed, assess general status, and response to therapy. Visit frequency based on prescribed dosage orders.

Additional Requirements:

Physician

MD:	License:	DEA #:	NPI #:
Specialty:	Practice:	Email:	Hospital/Clinic:
Phys. Phone:	Phys. Fax:	Address:	Office Contact:

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Physician; ☐ Other_____ *All the supplies including syringes and needles will be dispensed if requested.*

*This form is a generic referral form that could be utilized for any IVIG provider and is meant to provide the pertinent information needed to process an IVIG referral.
**If Nursing Services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.
*** ALL Fields must be completed to expedite prescription fulfillment.

Physician Signature: _____ ☐ DAW (Dispense as Written) Date:_____

By signing below, I authorize Streamline DBA Decillion Healthcare ("Streamline DBA Decillion Healthcare") to: Collect my health condition and prescription information from my doctor, healthcare provider, health insurer or pharmacist in order to ensure its accuracy and completeness and to communicate to the patient support program of the pharmaceutical manufacturer (the "Program"); and contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and patient assistance programs on my behalf to determine if I am eligible for assistance. I hereby authorize my doctor, healthcare provider, health insurer or pharmacist to provide my health condition and prescription information to Streamline DBA Decillion Healthcare and to the Program. I understand that I may revoke this authorization at anytime by sending a letter to Streamline DBA Decillion Healthcare.

Patient Signature:_____ Date:_____