Immunoglobulin for Primary Humoral Immunodeficiencies

Referring Physician Order Form

Please fax completed referral form & all required documents to 770-618-9617

CPS | INFUSION

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Hereditary hypogammaglobulinemia, D80.0

☐ Nonfamilial hypogammaglobulinemia, D80.1

☐ Selective deficiency of IgG subclasses, D80.3

☐ Antibody deficiency with near-normal Ig or with Hyperimmunoglobulinemia, D80.6

Common Variable Immunodeficiency (CVID)

☐ CVID with predominant abnormalities of B-cell, D83.0

☐ CVID with predominant immunoregulatory T-cell disorder, D83.1

☐ CVID with autoantibodies to B- or T-cells, D83.2

☐ Other CVID, D83.8

☐ CVID, unspecified, D83.9

☐ Other: _____, ICD 10 _____

INFUSION ORDERS

MEDICATION	DOSE, DIRECTIONS, and DURATION
IVIG ☐ Octagam 5% ☐ Octagam 10% ☐ Bivigam 10% ☐ Other Brand and Conc: _____	☐ **0.4 gm/kg** (_____ gm* total) Infuse IV every _____ weeks x _____ months ☐ **0.6 gm/kg** (_____ gm* total) Infuse IV every _____ weeks x _____ months ☐ ____ **gm/kg** (_____ gm* total) Infuse IV every _____ weeks x _____ months *Specify total calculated dose in grams per infusion and order to the nearest 5 grams. Ramp up infusion over 90 minutes to maximum rate of 150 mL/hr (10% IVIG) or 250 mL/hr (5% IVIG), or as tolerated, then ramp down over 1 minute.

Is patient currently receiving therapy above from another facility? ☐ **NO** ☐ **YES**

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by**:** ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

PRE-MEDICATION ORDERS:

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO

☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV

☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

☐ **See Attached Medical Records**

☐ Yes ☐ No Does the patient have documented history of recurrent bacterial sinopulmonary infections?

- ☐ Required multiple courses or prolonged antibiotic therapy
- ☐ Failure of prophylactic antibiotic therapy
- ☐ Hospitalizations for URI in the past 12 months
- ☐ Other: _____

☐ Yes ☐ No Does the patient have documented low pretreatment IgG level?

☐ Yes ☐ No Does the patient demonstrate inadequate antibody response to polysaccharide and/or protein antigen(s)?

If Yes, please attach pre- and post-vaccination titer labs performed prior to initiation of Ig.

If No, specify reason why antibody challenge was not completed: _____

- ☐ Pneumovax, Date of Vaccination: _____
- ☐ Prevnar, Date of Vaccination: _____
- ☐ Tetanus/Diphtheria, Date of Vaccination: _____
- ☐ Hemophilus, Date of Vaccination: _____

For continuation of therapy requests:

☐ Yes ☐ No Has the patient shown clinical improvement on therapy (e.g., reduction in frequency and/or severity of infections, decreased hospitalization, reduction in number of missed school or workdays, improved quality of life, etc.)?

LAB AND TEST RESULTS (required)

☐ Immunoglobulin (IgG total, IgG subclasses, IgA, and IgM), serum levels ☐ Other: _____

☐ Vaccine Challenge (pre-/post-vaccination serotype titers)