

# One Source Homecare - IVIG Order Form

Fax Referral To: 866-466-2270

Toll Free Phone: 866-466-2273

E-mail Referral To: [Info@onesourcehomecare.org](mailto:Info@onesourcehomecare.org)

## IV-SQ Immune Globulin Referral

### 1 PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ DOB: \_\_\_\_\_  
Alternate Phone: \_\_\_\_\_ Gender:  Male  Female  
E-mail: \_\_\_\_\_  
Last Four of SS #: \_\_\_\_\_ Primary Language: \_\_\_\_\_

### 2 PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_  
State License #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
DEA #: \_\_\_\_\_  
Group or Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

**3 INSURANCE INFORMATION** Please fax copy of prescription and insurance cards with this form, if available (front and back)  
Please fax prescription for drug, flushes and supplies

### 4 DIAGNOSIS AND CLINICAL INFORMATION

Primary Immune Deficiency (please state specific condition and ICD-9 code): \_\_\_\_\_

- 204.9 Chronic Lymphocytic Leukemia
- 279 Immune Mechanism Disorder
- 279.0 Deficiency of Humoral Immunity
- 279.06 Common Variable Immunodeficiency
- 279.3 Immunity Deficiency NOS
- 287.31 Idiopathic Thrombocytopenia
- 357.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- 446.1 Kawasaki Syndrome
- Other: \_\_\_\_\_

Patient previously received IVIG?  Yes  No  
Date of last infusion: \_\_\_\_\_  
Height: \_\_\_\_\_ In  
Weight: \_\_\_\_\_ kg / lbs  
Allergies: \_\_\_\_\_  
Nursing needed?  Yes  No  TBD  
Agency of choice: \_\_\_\_\_  
If no, reason:  Trained to self-administer  
 MD office to administer to patient  
 Home health nursing already coordinated  
Agency: \_\_\_\_\_

### 5 PRESCRIPTION INFORMATION

MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Carimune <input type="checkbox"/> Flebogamma DIF <input type="checkbox"/> 5% <input type="checkbox"/> 10% <input type="checkbox"/> GamaSTAN S/D <input type="checkbox"/> Gammagard Liq 10% <input type="checkbox"/> Gammagard S/D <input type="checkbox"/> Gammaked 10% <input type="checkbox"/> Gammaplex 5% <input type="checkbox"/> Gamunex-C 10% <input type="checkbox"/> Hizentra 20% <input type="checkbox"/> Octagam 5% <input type="checkbox"/> Privigen 10%	<input type="checkbox"/> IV <input type="checkbox"/> SQ <input type="checkbox"/> IM	_____ grams		<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Normal Saline <input type="checkbox"/> Heparin 10 units/mL <input type="checkbox"/> Heparin 100 units/mL <input type="checkbox"/> Other: _____	<input type="checkbox"/> IV				
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> 25-52mg <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pre-Med <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 325 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> 1 gram <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pre-Med <input type="checkbox"/> Other: _____	<input type="checkbox"/> Once <input type="checkbox"/> 1 month <input type="checkbox"/> 3 month <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Epi-Pen <input type="checkbox"/> Epi-Pen Jr. <input type="checkbox"/> Other: _____	<input type="checkbox"/> IM	<input type="checkbox"/> One Pen <input type="checkbox"/> Two Pens <input type="checkbox"/> Other: _____	<input type="checkbox"/> PRN Anaphylaxis <input type="checkbox"/> Other: _____		

Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

**6** X \_\_\_\_\_  
DISPENSE AS WRITTEN (Date)

X \_\_\_\_\_  
PRODUCT SUBSTITUTION PERMITTED (Date)

**IMPORTANT NOTICE:** This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. IGIV and General Immune Disorders 111612