ContinuumRx
Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

Immune Globulin Referral Form

Last 4 SSN#: ________

Date:_________ Patient Name: ________________________ DOB: __________ Phone: ______________ Male ☐ Female ☐

Patient Address: ______________________________ Insurance Name & ID#:______________________

Referral Contact Name & Number: ______________________ Insurance Name & ID#:______________________

Select Applicable Diagnosis and Include Recent Visit Notes and Diagnosis Specific Supporting Clinical Noted:

Immunology (ICD Codes)

Common Variable Immunodeficiency (D83.9) Documented hx recurrent infections, low total pre-treatment IgG level, pre/post pneumo titers within 4-8 wks showing poor polysaccharide vaccine response

IgG Subclass Deficiency (D80.3) Documented hx recurrent infections, one or more low pre-treatment IgG subclasses (IgG1, IgG2, IgG3, IgG4), pre/post pneumo titers within 4-8 wks showing poor polysaccharide vaccine response

Specific Antibody Deficiency (D80.6) Documented dx and hx recurrent infections, Normal quantitative Ig levels, pre/post pneumo titers within 4-8 wks showing poor polysaccharide vaccine response

Severe Combined Immunodeficiency (D81.9) Documented dx confirmed by genetic or molecular testing, pre-treatment low IgG level, very low/absent # T cells

Agammaglobulinemia (D80.0) Documented dx confirmed by genetic or molecular testing, pre-treatment low IgG level, very low or absent number T cells

Nonfamilial Hypogammaglobulinemia (D80.1) Documented hx recurrent infections, pre-treatment low IgG level (usually secondary or acquired)

Dermatology/Rheumatology (ICD Codes)

Pemphigus Vulgaris (L10.0) Dx confirmed by biopsy and pathology report, hx rapidly progressing, extensive or debilitating condition and failed standard treatments (corticosteroids, immunosuppressive agents)

Dermatomyositis (M33.90)/Polymyositis (M06.9) Documented dx, evidence of failed first line treatments (corticosteroids or immunosuppressants, testing (elevated muscle enzymes, muscle biopsy, skin biopsy)

Stiff Persons Syndrome (G25.8) Documented dx and hx of first line treatments, anti-GAD antibody testing

Neurology (ICD Codes)

Chronic Inflammatory Demyelinating Polyneuropathy (G61.81) Documented dx, progressive neurological symptoms, Electromyogram/Nerve Conduction (EMG/NCS), CSF (if available)

Multifocal Motor Neuropathy (G61.82) Documented dx & hx, Electromyogram/Nerve Conduction (EMG/NCS)

Guillain-Barre Syndrome (G61.0) Documented dx & hx of illness

Myasthenia Gravis (G70.0/G70.01) Documented dx & worsening symptoms, + acetylcholine receptor (AChR) abs

Multiple Sclerosis (G35) Documented dx of relapsing-remitting MS and previous treatments, diagnostic testing (ex. Neuro exam, MRI, +CSF study)

Transplant (ICD Codes)

Bone Marrow Transplant/Stem Cell Transplant Recipients (Z94.81/Z94.84) Documented hx infection, date of Tx, pre-treatment low total IgG level

Solid Organ Transplant (Z94.___)Documented dx & hx including indication for IVIG:

- Pre-transplant: high panel reactive antibody to human leukocyte antigens (HLA) (T86.91)
- Post-transplant: Graft vs Host Disease (D89.810)
- Post-transplant: recipients at risk for CMV (T86.0)
- Post-transplant: treatment for antibody mediated rejection (T86.11)

Other (ICD Codes)

B-cell Chronic Lymphocytic Leukemia (C91.11) Documented hx recurrent infections and date of Tx, pre-treatment low IgG level

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Detailed Written Orders:

Height: _____ ☐ inches ☐ cm Weight: ______ ☐ lbs ☐ kg

Allergies: ______________________

☐ IVIG (pharmacist to brand)	☐ SCIG (pharmacist to brand)
☐Gamunex-C (J1561)	☐Hizentra (J1559)
☐Gammagard (J1569)	☐Xembify (J1558)
☐Privigen (J1459)	☐HyQvia(J1575)
☐Panzyga (J1599)	☐Cutaquig(J3590)
☐__________(other)	☐ __________(other)

Dose: ______________________________________

Frequency: ____________________ Duration: __________

☐ Pharmacist to dose

Premedication: ☐ Diphenhydramine 25mg PO ☐ Acetaminophen 650mg PO

☐ Hydration: ______________________________

Other: ______________________________

☐ Pharmacy OK to Substitute Brand when Insurance Dictates

First Lifetime Dose: Yes:☐ IgA level: ______ N/A: ☐

No:☐ Previous Brands:______________________

Date of Last Dose:_______ Next Dose Due: ___________

Lab Orders: ______________________

Fax Lab Results To: ______________________

Ancillary orders will include:

Skilled Nursing Visits to administer (IVIG) and/or teach (SCIG) Infusions
NaCl 0.9% 5-10ml IV before and after infusion for peripheral access and PRN
Heparin 100 units/ml 3-5ml IV after infusion for Port IV access and PRN
All infusion supplies necessary to administer the medication
Anaphylaxis Kit

___IV E0781 Pump, A4221 Cath Supplies, A4222 Pump Supplies

___SQ K0552 Pump, A4221 Cath Supplies, A4222 Pump Supplies

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form & utilizing our services, I am also authorizing ContinuumRx to serve as my prior authorization agent with medical & pharmacy insurance providers.

Physician Signature: ______________________________ Date: ___________

Physician Name: (Please print) ______________________________

Phone: ______________ Fax: ______________ NPI #: ______________

Phone Orders Received From: ______________________ Date/Time: ___________

Referral Checklist:

- ☐ Patient Demographics
- ☐ Copy Insurance Card
- ☐ Signed Orders Including Date, Dose, Freq, Duration
- ☐ Office/Hospital Visit Notes (within 3-6 months)
- ☐ Clinical Supporting Dx
- ☐ Pertinent Labs & Testing
- ☐ Tried & Failed Therapies