CONTINUUMRx
Specialty Infusion Services

Please fax completed referral to Fax: 877-438-9380

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
- ☐ _____

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