MedPro Rx™
A DIPLOMAT® COMPANY

Immune Globulin Referral Form

Phone: (888) 571-3100 • Fax: (800) 582-9315

Date: _____

Demographics

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Phone: (*h*) _____ (*w*) _____

(*c*) _____ SS#: _____

HT: _____ WT: _____ Next of Kin: _____

Insurance Information: *MAY FAX DEMOGRAPHIC SHEET*

Primary Insurance: _____

Member ID #: _____ Group #: _____

Policy Holder: _____ Relationship: _____

Secondary Insurance: _____

Member ID #: _____ Group #: _____

Policy Holder: _____ Relationship: _____

Physician Orders: *(Please check the following)*

☐ IVIg Dose _____ grams/ kg / day X _____ days

or _____ grams / day X _____ days.

Interval (frequency of therapy): _____

# of refills: _____

☐ Benadryl 25 – 50 mg PO _____

☐ Benadryl 25 – 50 mg IV _____

☐ Tylenol 650 or 1000 mg PO _____

☐ IV Steroids: _____ Dose: _____ Pre / Post

☐ IV Hydration: _____ Pre / Post

☐ *Anaphylaxis Kit per protocol*

☐ 0.9 % sodium chloride 5-10ml pre/post infusion and PRN

☐ Heparin 100units/ml 5ml post infusion and PRN

☐ Heparin 10units/ml 5ml post infusion and PRN

☐ Skilled Nursing visits as required

☐ Standard supplies as needed

☐ First dose to be given in home

Has the patient received IVIg previously? ☐ Yes ☐ No

Date of last dose: _____ Allergies: _____

Anticipated Start Date: _____

Diagnosis: *(Please check one of the following)*

☐ 357.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

☐ 333.91 Stiff Person Syndrome

☐ 358.00 Myasthenia Gravis **without acute exac.**

☐ 358.01 Myasthenia Gravis with **acute exac.**

☐ 340.0 Multiple Sclerosis **relapsing/remitting only**

☐ 356.4 Polyneuropathy Idiopathic, **Progressive**

☐ 357.0 Guillian-Barre Syndrome (acute infective polyneuritis)

☐ 710.4 Polymyositis

☐ 710.3 Dermatomyositis

☐ 357.9 Multifocal Motor Neuropathy

☐ 279.06 Common Variable Immune Deficiency (CVID)

IgG Level: _____ Date: _____

☐ 279.00 Hypogammaglobulinemia

IgG Level: _____ Date: _____

☐ 287.31 Thrombocytopenia (ITP)

Plt Count: _____ Date: _____

☐ 776.1 Transient Neonatal Thrombocytopenia

☐ Other: _____

ICD-9 Code: _____

Prescribing Physician:

Name: _____

Address *(please include facility name)*:

_____

_____

_____

Phone: _____ Fax: _____

Specialty: _____

License #: _____ UPIN #: _____

DEA #: _____ NPI #: _____

I have read this entire form and verify to its accuracy ☐ Yes

Prescriber Signature: _____
Dispense as written

Prescriber Signature: _____
Substitution allowed

Date: _____

Please CLICK HERE to email this form automatically, or attach manually to: referrals@medprorx.com

Or Fax Completed Copies of the Following to MedPro Rx @ 1-800-582-9315: (1) Referral Form and (2) Your Insurance Card(s)

MedPro Rx, Inc. is compliant with HIPAA Guidelines