IVIG (Immune Globulin) Referral Order Form

WWW.PACEINFUSION.COM
PH:330-625-4900
F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions *indicate name of drug(s)

_____

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

IVIG MEDICATION ORDERS

Medication: ☐ Gammagard ☐ Gammaplex _____ ☐ Gamunex C ☐ Octagam _____ ☐ Privigen ☐ Hizentra

Patient Weight: _____ kg Dose: _____ Frequency: _____

INDICATION/DIAGNOSIS

☐ Chronic Immune Thrombocytopenia purpura (ITP)
☐ Primary Humoral Immunodeficiency (PI)
☐ Primary Immunodeficiency (PID)
☐ Multifocal Motor Neuropathy (MMN)
☐ Other _____

***ICD-10 _____ required**

_____ _____
Referring Physician's Signature Date

NOTES (ADDITIONAL INFO)

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report (w/in past 6 months)

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ Serum creatinine w/ eGFR
☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months
☐ IgA Deficient

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY