



Immune Globulin (IVIG / SCIG) Referral Form

Home Infusion Prescription & Referral

Patients / caregivers: complete sections 1–2 and give this form to your prescriber. Prescribers: complete sections 3–7, sign, and fax with attachments to 855-872-5872.

Referral type: ☐ New referral ☐ Renewal / re-order ☐ Dose or frequency change ☐ Discontinue therapy Needed by

Administer at: ☐ Patient's home ☐ Prescriber's office ☐ Infusion suite ☐ SNF / other ☐ Hold until notified Start date

1 PATIENT INFORMATION

Last name First name MI Date of birth Sex: ☐ M ☐ F
 Street address City State ZIP
 Primary phone Alternate phone Email Preferred language
 Caregiver / emergency contact Relationship Phone **OK to leave voicemail?** ☐ Yes ☐ No

2 INSURANCE & BILLING INFORMATION

Attach copies of ALL insurance cards, front and back

Primary insurance Member ID Group # Plan phone
 Subscriber name Subscriber DOB Relationship to patient Medicare ID (MBI) Medi-Cal CIN
 Secondary insurance Member ID Group # Plan phone
 Rx card (if separate) Rx ID RxBIN RxPCN RxGroup **Coverage:** ☐ Medicare ☐ Medi-Cal ☐ Commercial / PPO ☐ HMO / IPA
Prior authorization: ☐ Not started — Biologic to obtain ☐ Pending ☐ Obtained Auth # Valid dates IPA / case manager

3 PRESCRIBER & REFERRAL SOURCE

Prescriber name Credentials NPI State license #
 Practice / group Phone Fax
 Address City State ZIP
 Office contact Direct phone / ext Contact email Supervising MD (if NP/PA)
 Referral source (if different) Hospital / facility Discharge planner / case manager Phone Discharge date

4 DIAGNOSIS & CLINICAL INFORMATION

Check all that apply — codes below are common indications, not a substitute for the chart

Primary dx ICD-10	Description	Secondary dx ICD-10	Description
☐ D80.0 X-linked agammaglobulinemia	☐ C91.10 CLL (w/ hypogammaglobulinemia)	☐ G70.80 Lambert-Eaton syndrome	
☐ D80.1 Nonfamilial hypogammaglobulinemia	☐ D69.3 Immune thrombocytopenia (ITP)	☐ G25.82 Stiff-person syndrome	
☐ D80.3 IgG subclass deficiency	☐ M30.3 Kawasaki disease	☐ M33.20 Polymyositis	
☐ D80.5 Immunodeficiency w/ increased IgM	☐ G61.0 Guillain-Barré syndrome	☐ M33.90 Dermatomyositis	
☐ D81.9 Combined immunodeficiency (SCID)	☐ G61.81 CIDP	☐ L10.0 Pemphigus vulgaris	
☐ D83.9 Common variable immunodef. (CVID)	☐ G61.82 Multifocal motor neuropathy	☐ T86.11 Kidney transplant rejection	
☐ D84.9 Immunodeficiency, unspecified	☐ G70.00 / .01 Myasthenia gravis	☐ Z94.- Transplant status (specify organ)	

Height in Weight lb / kg Date ☐ NKDA Allergies & reactions

Vascular access: ☐ None — needs placement ☐ Peripheral ☐ Midline ☐ PICC ☐ Port ☐ Tunneled CVC Lumens Date placed

Baseline IgG mg/dL IgA mg/dL Date ☐ IgG subclasses attached ☐ Vaccine response attached ☐ BUN / SCr attached

Prior IG therapy? ☐ No ☐ Yes Product Dose / frequency Last infusion Reactions

Supporting clinical history (infection history, neurologic deficits, failed therapies)

Please attach: ☐ Face sheet ☐ Insurance cards (front & back) ☐ H&P / progress notes ☐ Medication list ☐ Quantitative Igs / BUN / SCr
☐ Infection hx / EMG-NCS reports

Patient name DOB Prescriber

5 PRESCRIPTION — IMMUNE GLOBULIN

Complete IV or SC section. Dosing weight is the weight on page 1 unless noted.

Route: ☐ IV (IVIG) ☐ SC (SCIG) Dosing weight kg Product: check a brand below, or leave blank for Biologic to select per payer formulary.

Intravenous immune globulin (IVIG)

- | | | | |
|---|---|--|--------------------------------------|
| ☐ Gammagard Liquid 10% | ☐ Privigen 10% | ☐ Flebogamma DIF 5% / 10% | ☐ Yimmugo 10% |
| ☐ Gammagard S/D 5% / 10% | ☐ Octagam 5% / 10% | ☐ Asceniv 10% | |
| ☐ Gamunex-C 10% | ☐ Panzyga 10% | ☐ Gammaplex 5% / 10% | |
| ☐ Gammaked 10% | ☐ Bivigam 10% | ☐ Alyglo 10% | |

☐ Loading / induction dose: g/kg = g total, divided over consecutive day(s) ☐ Then maintenance below

☐ Maintenance dose: g/kg or g total, over day(s), every week(s) × courses ☐ × 12 months

Rate: ☐ Per product labeling, titrate per Biologic protocol Max rate ☐ OK to round to nearest vial ☐ ± 4 days scheduling flexibility

Subcutaneous immune globulin (SCIG)

- | | | | |
|---------------------------------------|---|--|---|
| ☐ Hizentra 20% | ☐ Xembify 20% | ☐ HyQvia 10% (w/ hyaluronidase) | ☐ Gamunex-C 10% (SC) |
| ☐ Cuvitru 20% | ☐ Cutaquig 16.5% | ☐ Gammagard Liquid 10% (SC) | ☐ Gammaked 10% (SC) |

Dose g (mL) every ☐ week(s) ☐ day(s) # of sites Max mL / site ☐ Convert from IV dose — Biologic to calculate

Pump: ☐ Mechanical / syringe pump per Biologic ☐ Manual push Other SC instructions

Hydration: ☐ None ☐ 0.9% NaCl 250 mL pre-infusion ☐ 0.9% NaCl 500 mL pre-infusion Special instructions

6 PRE-MEDICATIONS, NURSING & MONITORING

Pre-medications: ☐ None ☐ Acetaminophen 650 mg PO (325 mg if < 45 kg) ☐ Diphenhydramine 25 mg PO ☐ Methylprednisolone 40 mg IV

Other pre-medication (drug, dose, route) ☐ May repeat diphenhydramine × 1 in 30 min PRN

Standing orders included with every referral unless declined: anaphylaxis / infusion-reaction kit per Biologic protocol (epinephrine, diphenhydramine PO/IV, 0.9% NaCl), saline / heparin flushes per access device, lidocaine-prilocaine cream PRN for access, infusion pump and supplies, ancillary refills × 12 months.

☐ Decline / modify standing orders:

Nursing: ☐ Skilled RN to administer in home ☐ First dose OK in home ☐ First dose in clinic / suite ☐ Teach self-administration (SCIG)

Labs: ☐ BUN / SCr before first dose & annually ☐ IgG trough before dose # ☐ CBC Other ☐ Fax results to prescriber

7 PRESCRIBER AUTHORIZATION

Original signature required — no stamps

I certify that the immune globulin therapy ordered above is medically necessary, that the patient is under my care, and that I will supervise the patient's treatment. Unless otherwise indicated, orders are valid for 12 months from the date signed. I authorize Biologic Infusion Pharmacy to act as my agent and on behalf of my patient to initiate and complete prior authorization, appeals, and related processes with the patient's health plan(s), including submission of any required forms and clinical documentation. Biologic may release medical information to the patient's health plan(s) and to the home health agency as needed to coordinate care. This authorization may be revoked in writing at any time.

Product selection: ☐ Substitution permitted — Biologic may select product per payer formulary / availability ☐ Dispense as written

Refills x 12 months unless otherwise noted Verbal order taken by / date (pharmacy use)

Prescriber signature (no stamps)	Print name & credentials	Date

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