IVIG Prescription Referral Form

Carepoint Pharmacy
Phone: 732-885-1000 **Fax: 732-980-0357**
10 Plainfield Ave., Suite 1, Piscataway, New Jersey 08854 www.carepointpharmacynj.com

Complete Patient Demographic Information in Section Below OR Attach Face Sheet from Patient Chart

First Name :	*Middle Initial :*	*Last Name :*	
Date of Birth :	*Gender:* ◯ M ◯ F	*SSN :*	
Street Address :	*City :*	*State :*	*Zip Code :*
Home Phone :	*Work Phone :*	*Cell Phone :*	

Complete Patient Insurance Information in Section Below OR Attach Copies of Patient Insurance Card

Insurance Carrier Name - Primary :	*Name of Insured :*		*Relationship :*
ID# :	*Group # :*		*Insurance Phone :*
Rx Carrier Name - Secondary :	*Rx ID# :*	*Rx Group #:*	*Rx Phone # :*

Complete Drug Therapy Information in Section Below OR Attach Completed Prescription

☐ IVIg

Dose _____ grams/kg/day X _____ days

or _____ grams/kg/day X _____ days

Directions for administration:

Route of Administration : ☐ IV ☐ SC ☐ IM

# of refills: _____

Ig Product: _____ ☐ Don Not Substitute

Access Device for IV : ☐ Peripheral catheter ☐ Other _____

Epinephrine :

☐ Patient weight ≥ 30 kg; inject 0.3mg IM PRN for adverse reaction to IVIG

☐ Patient weight 15 - 30kg; inject 0.15mg IM PRN for adverse reaction to IVIG

☐ ICD - 10 _____ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

☐ ICD - 10 _____ Congenital Hypogammaglobulinemia

☐ ICD - 10 _____ Immunodeficiency with increased IgM

☐ ICD - 10 _____ Wiskott - Aldrich Syndrome

☐ ICD - 10 _____ Combined Immunity Deficiency

☐ ICD - 10 _____ Myasthenia Gravis **without ac ute exac.**

☐ ICD - 10 _____ Myasthenia Gravis **with acute exac.**

☐ ICD - 10 _____ Multiple Sclerosis **relapsing/remitting only**

☐ ICD - 10 _____ Polyneuropathy Idiopathic, **Progressive**

☐ ICD - 10 _____ Guillian - Barre Syndrome

☐ ICD - 10 _____ Multifocal Motor Neuropathy

☐ ICD - 10 _____ Common Variable Immune Deficiency (CVID)

IgG Level: _____ Date: _____

☐ ICD - 10 _____ Hypogammaglobulinemia

IgG Level: _____ Date: _____

☐ ICD - 10 Other: _____

ICD - 10 Code:

Allergies :	*Weight :*

Current Therapies/Medications:

☐ Infused at MDO ☐ Infused at home: Set up of Skilled nursing visits required

Complete Prescriber Information in Section Below NOT Included on Attached Prescription

MD First Name :	*MD Last Name :*		*DEA # :*	
UPIN :	*State License # :*	*NPI :*		
Office Address :		*City :*	*State :*	*Zip Code :*
Office Phone:		*Office Fax :*		*Office Email:*

Office Contact Name:

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS

☐ *I authorize Carepoint Pharmacy to initiate a Prior Authorization on my behalf.*	**Date :**
Dr : Substitution Permitted	**Dr :** No Substitution Permitted