briova Rx® Infusion Services

Neurology Immunoglobulin Referral Form

Phone: **1-877-342-9352**
Fax: 1-888-594-4844

PATIENT INFORMATION

IG specialist Name: _____
Phone: _____

Patient ☐ see attached Gender: O Male O Female
Patient name: _____
DOB: _____ SSN: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Cell: _____
Emergency contact: _____
Phone: _____ Relationship: _____

Insurance ☐ Front and back of insurance card to follow

	Primary	Secondary
Insurance:		
Phone:		
Policy #:		
Group:		

Primary diagnosis
- ☐ Acute Infective Polyneuritis (Guillain–Barre Syndrome)
- ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ Critical Illness Polyneuropathy (Acute Motor Neuropathy)
- ☐ Dermatomyositis
- ☐ Multifocal Motor Neuropathy (MMN)
- ☐ Multiple Sclerosis (MS)
- ☐ Myasthenia Gravis with (Acute) Exacerbation
- ☐ Myasthenia Gravis without (Acute) Exacerbation
- ☐ Peripheral Neuropathy (Unspecified)
- ☐ Polymyositis
- ☐ Stiff-Person Syndrome
- ☐ Other: _____

Medical assessment
Height: _____ Weight: _____ O lbs O kg
Current medications: O Yes O No
If yes, list or attach: _____
Allergies: _____

PRESCRIPTION ORDERS

Immune Globulin:
- ☐ No preference
- ☐ Preferred product: _____

Directions:
- ☐ Infuse IV ☐ Infuse SC
- ☑ Per manufacturer guidelines or as written below:

_____
- ☑ May round to the nearest 5gm vial size

Pre-medications 30 minutes before start of IG:
- ☐ Acetaminophen PO O 325 mg O 500 mg O 650 mg
- ☐ Diphenhydramine PO O 25 mg O 50 mg
- ☐ Hydration, solution: _____ Volume _____ mL
- ☐ Other: _____

Nursing and other orders:
- ☑ Administer IVIG or teach SCIG self-administration, via pump
- ☑ Ambulatory pump if required for infusion
- ☑ Initiate access device (insert peripheral IV, SC needles, access implanted port, or use existing PICC)
- ☑ Flush PIV with 5mL NS (for other orders, contact physician)
- ☐ Obtain labs (list): _____

Lab frequency: ☐ Once ☐ Monthly ☐ Other:

Initial: _____ gm/kg divided over _____ days
Ongoing: _____ gm/kg divided over _____ days
every _____ weeks for _____ cycles

Quantity/Refills:
- ☐ 1-month supply; refill x 12 months unless otherwise noted
- ☐ Other: _____

☑ Infusion reaction management and kit order

Mild	Slow infusion rate by 50% until symptoms resolve Diphenhydramine PO O 25 mg O 50 mg ☐ other: _____
Moderate	Stop infusion, resume at 50% when symptoms resolve Diphenhydramine IV O 25 mg O 50 mg ☐ other: _____
Severe (Anaphylaxis) *Call 911*	Stop infusion; initiate 0.9% NaCl 500 mL IV Administer epinephrine 1 mg/mL by weight (Wt): Wt > 66 lbs (30 kg) = 0.3 mg/.3mL | Wt 33 - 66 lbs (15 - 30 kg) = 0.15 mg/0.15mL | Wt < 33 lbs (<15 kg) = 0.01 mg/kg Repeat epinephrine in 5-15 min if symptoms continue. Administer CPR if needed until EMS arrives.

PHYSICIAN INFORMATION

Name: _____ Address: _____
Practice: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ NPI: _____ Contact: _____

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Substitution permissible Signature: _____ Date: _____ *Dispense as written* Signature: _____