briovaRx® Infusion Services

Phone: **1-877-342-9352**
Fax: 1-877-542-9352

Neurology Immunoglobulin Referral Form

IG specialist information

Name: _____

Phone: _____

Patient information

Patient name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

DOB: _____ SSN: _____

Gender: ☐ Male ☐ Female

Emergency contact: _____

Phone: _____ Relationship: _____

Insurance information

Primary insurance: _____

Phone: _____ Subscriber: _____

Policy #: _____ Group: _____

Prescription drug card: _____

Policy #: _____ Phone: _____

Secondary insurance: _____

Phone: _____ Subscriber: _____

Policy #: _____ Group: _____

Primary diagnosis

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

Medical assessment

Height: _____ Weight: _____ ☐ lbs ☐ kg

Advanced directives? ☐ Yes ☐ No

Kidney or heart disease? ☐

☐ Diabetic What is the current A1c? _____ mg/dL

Ambulatory? ☐ Yes ☐ No

Homebound? ☐ Yes ☐ No

Is patient currently on any medications? ☐ Yes ☐ No

List: _____

_____

Allergies: _____

Prescription and orders

Is this the first dose? ☐ Yes ☐ No

If no, list product: _____

Date of last infusion: _____ Next dose due: _____

Administer Ig: ☐ IV

Initial: ☐ ___ gm/kg or _____ grams daily x ____ days

Ongoing: ☐ ___ gm/kg or ___ grams every ___ wk(s) for ___ cycle(s)

☐ Collect Care Exchange® data (per BriovaRx Infusion Services protocol)

Other orders

Pre-medication:

☐ Acetaminophen 325mg; 1-2 tabs every 4-6 hours as needed, not to exceed 8 tabs per day.

☐ Diphenhydramine 25-50 mg orally before infusion as needed.

☐ Other: _____

Adverse/anaphylactic reactions (per BriovaRx Infusion Services protocol):

✓ Anaphylaxis kit (per BriovaRx Infusion Services protocol).

✓ Mild reaction give Diphenhydramine 50mg (two tabs), slow infusion. If needed give two additional tabs (50mg).

✓ Moderate reaction give 50mg Diphenhydramine (two tabs) and stop infusion.

✓ Severe reaction with breathing problem give 50mg IV Diphenhydramine; EpiPen; 500ml Nacl 0.9% fluid and call 911.

Nursing: ☑ Start PIV or SQ as required for administration and nurse to administer infusion in home.

Access: ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____

Flushing: ☑ BriovaRx Infusion Services protocol (heparin, 0.9% NaCl, D5W)

Labs: _____

Physician information

Physician: _____

Practice: _____

Address: _____

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.

Physician signature: _____ Date: _____

(Substitution permissible, signature required)

Physician signature: _____ Date: _____

(Substitution permissible, signature required)