BioPlus Infusion — A CAREPATHRx Company | Santa Barbara Pharmacy

E-prescribe the *Fast & Easy* way: select **BioPlus** from your EHR!

SUBQIG REFERRAL FORM

Fax: 866-523-5406

bioplusinfusion.com Phone: 800-829-3975

Ship To: ☐ **In Office** ☐ **Infusion Suite** ☐ **At Home** ☐ **Other**_____

PATIENT INFORMATION

Patient Name:	SSN:		DOB:
Address:	City:	State:	Zip:
Home Phone:	Height:	Weight:	Gender: ◯ Male ◯ Female
Cell Phone:	Email Address:		

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance Co:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

CLINICAL INFORMATION (Fax all pertinent clinical and lab information)

Diagnosis (ICD-10): _____ **Date of Diagnosis:** _____

Common Variable Immune Deficiency (CVID) Other CVID (Part B) D83.9 or D83.8 Combined Immune Deficiency 81.9 Severe Combined Immune Deficiency D81.1, D81.2 Hypogammaglobulinemia D80.1
Other Combined Immune Deficiencies D81.89 Immune-mediated Thrombocytopenia Purpura (ITP) D69.3 Kawasaki Disease M30.3 Wiskcott-Aldrich Syndrome D82.0

Has patient received immune globulin previously? ☐No ☐ Yes: Date of last infusion _____ Date of next infusion: _____

Comorbidities:_____

ALLERGIES: ☐ NKDA ☐ Other_____

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Subcutaneous IG Therapy:

Preferred brand _____ **OR** ☐ Pharmacist will determine appropriate product based on clinical assessment, insurance requirements and availability

☐ Refills: _____times (as allowed by state or payer requirements)

Directions:

☐ Administration Rate = Follow Manufacturer's Guidelines ☐ Administer ____ mg per kg (+ or - 10%) ☐ Administer _____gm every _____days

Other Medication

☐ **Acetaminophen** 650 mg tablet ☐ Premedication:30 min before infusion PO ☐ Post infusion every 4-6 hours as needed for fever/headache.

☐ **Diphenhydramine** 25 mg capsule ☐ Premedication:30 min before infusion PO ☐ Post infusion every 4-6 hours as needed for itching/site reactions.

☐ **Lidocaine 2.5% and Prilocaine 2.5% cream** 30 g. Apply small amount topically to insertion site(s) prior to needle insertion as needed.

☐ **Other**_____ Strength:_____ Directions: _____

☐ **Other**_____ Strength:_____ Directions: _____

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution.	☐ Dispense as written

NURSING

☐ **Nursing Agency:** _____ **Phone:** _____

Skilled Nursing Visits for Immune Globulin SubQ administration and education of patient and/or caregiver to perform therapy independently when necessary. To provide education related to disease process and IG therapy. To provide an assessment of patient's general overall health status. To provide skilled nursing visits PRN for additional education and support.

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:		
NPI #:	Tax ID #	
Prescriber Signature:	Date	

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Sales Person: