briovaRx®
Infusion Services

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

Immunology 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

☐ Common variable immunodeficiency
☐ Common hypogammaglobulinemia
☐ Immunodeficiency with increased IgM
☐ Combined immunity deficiency
☐ Wiskott-Aldrich syndrome
☐ Immune thrombocyopenic purpura
☐ 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 ☐ Sub Q

☐ ________ gm/kg or ______ grams every ________ wk(s) for ______ cycles

☐ 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)

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