HealthQuest
Infusion & Specialty

1311 W Sam Houston Pkwy N Ste 100, Houston, TX 77043
T (832) 500-3727 **F** (832) 500-8629 **E** specialty@hqrx.com

IMMUNOGLOBULIN
IVIG / SCIG Referral Form

DATE:_____ NEXT TREATMENT DATE:_____

Please fax completed form along with copy of patient's insurance cards and any labs to (832) 500-8629

Patient Name _____
Patient Address _____
City _____ State _____ Zip _____
Day Phone _____ Work Phone # _____
Cell Phone _____
Date of Birth _____ ☐ Male ☐ Female
E-mail _____

Prescriber's Name _____
DEA # _____ NPI # _____
Practice Name _____
Office Contact _____
Address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____

DIAGNOSIS

Patient: Wt._____ Ht._____ Allergies: ☐ Latex ☐ Other, specify _____

ICD-10 DIAGNOSIS CODE

- ☐ C91.1 Chronic Lymphocytic Leukemia
- ☐ D80.0 Congenital Hypogammaglobulinemia
- ☐ D80.1 Hypogammaglobulinemia
- ☐ D80.3 Other Selective Immunoglobulin Deficiency
- ☐ D80.4 Selective IgM Deficiency
- ☐ D80.5 Immunodeficiency with increased IgM
- ☐ D81.9 Combined Immunodeficiency, unspecified
- ☐ D82.0 Wiskott-Aldrich Syndrome
- ☐ D83.8 Other Deficiency of Humoral Immunity
- ☐ D83.9 CVID
- ☐ G61.0 GBS
- ☐ G61.81 CIDP
- ☐ G70.00 MG without acute exacerbation
- ☐ G70.01 MG with acute exacerbation
- ☐ Other: _____

PRESCRIPTION

☐ **IVIG** ☐ **SCIG** **Pharmacist to identify clinically appropriate brand/infusion rates. May substitute based on product availability.**

Loading Dose *(as applicable)*	_____	☐ mg/kg ☐ gm/kg ☐ grams	x ____ day(s) **OR** divided over ____ day(s)	☐ One time dose ☐ Other: _____ • *Give maintenance dose ____ weeks after loading dose*
Maintenance Dose	_____	☐ mg/kg ☐ gm/kg ☐ grams	x ____ day(s) **OR** divided over ____ day(s)	☐ Q ____ Weeks x1 year ☐ Other

☐ Do not substitute. Administer brand: _____
- Infuse entire contents of Ig infusion bag/vial(s) per current dose.
- If needed, round dose to nearest whole 5 gm vial for IV doses and nearest single-use vial size for subQ doses.

Pre-medication orders: to be administered 15–30 minutes before infusion

☐ Acetaminophen 500mg PO ☐ Normal Saline 500mL IV ☐ Cetirizine 10mg PO
☐ Solu-Medrol _____ mg IVP ☐ Diphenhydramine 25mg PO ☐ Quzyttir 10mg IVP
☐ Loratadine 10mg PO ☐ Diphenhydramine 25mg IV ☐ Other: _____

Lab orders: _____

Lab frequency: ☐ Each infusion ☐ Other: _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Anaphylactic Reaction Orders:
- Epinephrine (based on patient weight)
  - >30kg (>66lbs): Epinephrine 0.3mg IM or subQ; may repeat in 5–10 minutes x1
  - 15–30kg (33–66lbs): Epinephrine 0.15mg IM or subQ; may repeat in 5–10 minutes x1
- Diphenhydramine: Administer 25–50mg IV (adult) • NS 0.9% 500mL IV bolus as needed (adult)
- Refer to physician order or institutional protocol for pediatric dosing and infusion reaction management

Flush orders: NS 1–10mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

I authorize HealthQuest Infusion & Specialty and its representatives to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above as well as selecting the preferred site of care for the patient. I understand that I can revoke this designation at any time by providing written notice to HealthQuest Infusion & Specialty.

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ **DATE** _____

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COMPREHENSIVE SUPPORT FOR IMMUNOGLOBULIN THERAPIES

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

GENERAL REQUIREMENTS

- Patient demographics
- Patient's height and weight
- Insurance information
- Drug allergies
- All applicable diagnoses
- History and physical
- Physician Orders
- Recent progress notes within 12 months
- **See additional required documents below (if applicable)**

COMMON VARIABLE IMMUNODEFICIENCY (CVID) / HYPOGAMMAGLOBULINEMIA

- Most recent labs showing Ig levels and subclasses
- Documentation of recurrent infections
- History of antibiotic usage - showing failure to respond to antibiotics
- Documented inadequate response to pneumococcal vaccine or tetanus/diphtheria

CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP) / GUILLAIN-BARRE SYNDROME (GBS)

- Labs
- Nerve conduction study, electromyography (EMG)
- Nerve and/or muscle biopsy (if available)
- Nerve conduction velocity (NCV) test results
- Tried and failed treatments
- Spinal tap (if available)

MYASTHENIA GRAVIS

- Exacerbation
- Any history of crisis
- Thymectomy
- Any symptoms that affect respiration, speech, or motor function
- Tried and failed treatments

HealthQuest Infusion & Specialty will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please **fax** all information to **(832) 500-8629**