MedPro Rx™, Inc.

Specialized Pharmacy Services

Subcutaneous Immune Globulin Referral Form

Phone: (888) 571-3100 • Fax: (800) 582-9315

Date: _____

Demographics

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Phone: (*h*) _____ (*w*) _____

(*c*) _____ SS#: _____

HT: _____ WT: _____ Next of Kin: _____

Insurance Information: *MAY FAX DEMOGRAPHIC SHEET*

Primary Insurance: _____

Member ID #: _____ Group #: _____

Policy Holder: _____ Relationship: _____

Secondary Insurance: _____

Member ID #: _____ Group #: _____

Policy Holder: _____ Relationship: _____

Prescribing Physician:

Name: _____

Address *(please include facility name)*:

_____

_____

_____

Phone: _____ Fax: _____

Specialty: _____

License #: _____ UPIN #: _____

DEA #: _____ NPI #: _____

I have read this entire form and verify to its accuracy ☐ Yes

Prescriber Signature: _____
Dispense as written

Prescriber Signature: _____
Substitution allowed

Date: _____

Physician Orders: *(Please check the following)*

☐ **Hizentra 20% (200mg/mL):**
Total weekly Dose= _____ grams
Dispense: 4 week supply
Refill x _____

☐ **Gamunex-C 10% (100mg/mL):**
Total weekly Dose= _____ grams
Dispense: 4 week supply
Refill x _____

☐ **Gammagard Liquid 10% (100mg/mL):**
Total weekly Dose= _____ grams
Dispense: 4 week supply
Refill x _____

☐ **Gammaked Liquid 10% (100mg/mL):**
Total weekly Dose= _____ grams
Dispense: 4 week supply
Refill x _____

Other Orders: *(Please check all that apply)*

☐ Pharmacist to determine least number of sites for product administration based on manufacturer recommendations/restrictions

☐ 0.9% Sodium Chloride flush to verify correct SC needle placement

☐ **EpiPen** *(dose based on weight/age)*
Sig: Use as directed for anaphylactic reaction

☐ **Acetaminophen 650 mg**
Sig: Take by mouth every 4-6 hours PRN fever and/or headache

☐ **Diphenhydramine 25 mg**
Sig: Take by mouth every 4-6 hours PRN itching

Diagnosis: *(Please check one of the following)*

IgG Level: _____ Date: _____

☐ 279.00 Hypogammaglobulinemia
☐ 279.04 Congenital Hypogammaglobulinemia
☐ 279.05 Immunodeficiency with increased IgM
☐ 279.06 Common Variable Immune Deficiency (CVID)
☐ 279.12 Wiskott-Aldrich syndrome
☐ 279.2 Severe Combined Immunodeficiency (SCID)
☐ Other: _____

ICD-9 Code: _____

Please to email this form automatically, or attach manually to: referrals@medprorx.com

Or Fax Completed Copies of the Following to MedPro Rx @ 1-800-582-9315: (1) Referral Form and (2) Your Insurance Card(s)

MedPro Rx, Inc. is compliant with HIPAA Guidelines