BluHaven HEALTH

IVIG Referral Form

Fax: (984) 370-2352
Phone: (984) 370-2350
Email: connect@bluhaven.com

Patient Information

Name: _____ DOB: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Weight: _____ ☐ lbs ☐ kgs

Allergies: ☐ NKDA ☐ _____

Required Documentation Insurance Card | History & Physical | Patient Demographics | Most Recent Labs | Medication List | Current IG Levels

Primary Diagnosis

- ☐ D80.1 Nonfamilial hypogammaglobulinemia
- ☐ D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses
- ☐ D80.6 Antibody deficiency with near-normal IG
- ☐ D83.9 Common variable immunodeficiency, unspecified
- ☐ G35 Multiple sclerosis
- ☐ G61.81 Chronic inflammatory demyelinating polyneuritis
- ☐ G61.82 Multifocal motor neuropathy
- ☐ G70.00 Myasthenia gravis without (acute) exacerbation
- ☐ G70.01 Myasthenia gravis with (acute) exacerbation
- ☐ M33.2 Polymyositis
- ☐ M33.1 Dermatomyositis
- ☐ Z94.0 Kidney transplant status
- ☐ Other: _____

Order Information

Lab Orders (Include frequency)

Please list any labs to be drawn by the infusion clinic: _____

Pre-Medications

☑ Per infusion clinic protocol: No recommended standard pre-meds for IVIG

☐ Provider Prescribed: _____

Primary Medication Order

No Brand Preference:

☐ No brand preference - Immune Globulin Solution 10%

☐ No brand preference - Immune Globulin Solution 5%

Brand Preference:

☐ Other: _____

Dosing Orders

Dose: _____

☑ Refills x 12 months unless otherwise noted: _____

Line Use/Care Orders

☑ Start PIV/ACCESS CVC

☑ Flush device per BluHaven Health's protocol (see BluHaven.com for policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box.

Adverse Reaction & Anaphylaxis Orders

☑ Administer acute infusion reaction and anaphylaxis medications per BluHaven Healths' protocol (see BluHaven.com for policy)

☐ Other: Please fax other reaction orders if checking this box.

☐ Other Flush Orders: Please fax other line care orders if checking this box.

Provider Information

Name: _____ Office Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

_____ _____

Provider Signature *Date*