Immune Globulin Referral Form

CORNERSTONE PHARMACY — an affiliate of MEDICAL CENTRE PHARMACY

PATIENT INFORMATION (Complete or fax existing chart)

Patient Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Phone: ________________ 2nd Phone: ___________
DOB: __________________ Gender: Male Female
Weight: Ht: Allergies:

PRESCRIBER INFORMATION

Prescriber Name: ______________________________
State License: _______________ NPI #: _______________
DEA: __________________ Phone: __________________
Address: ______________________________
City, State, Zip: ______________________________
Contact Person: ______________ Phone: ____________

INSURANCE INFORMATION - INSTEAD - just send us a copy of the patients prescription / insurance cards (front & back)

Primary Insurance: ______________________________
City, State, Zip: ______________________________
Plan #: ______________________________
Group #: ______________________________
Phone: ______________________________

RX Card (PBM): ______________________________
BIN: ________________ PCN: ________________
City, State, Zip: ______________________________
Group #: ______________________________
Phone: ______________________________

DIAGNOSIS /CLINICAL INFORMATION

☐ D80.0 Congenital Hypogammaglobinemia	☐ D81.9 SCID (unspecified)	☐ D83.9 Common Variable Immunodeficiency
☐ G35 MS (Relapsing Remitting)	☐ G61.0 GBS	☐ G61.81 CIDP
☐ G61.89 MMN	☐ G70.00 MG W/O acute exacerbation	☐ G70.01 MG with acute exacerbation
☐ M33.20 Polymyositis	☐ M33.90 Dermatomyositis	
☐ Other Code:	Description:	

Needs by Date: Ship to: Patient Office Other:
Lab Orders:

PRESCRIPTION / ADMINISTRATION

Medication	Route	Dose	Directions		Refills
Immune Globulin Brand (any): ☐ Dispense As Written	☐ SC ☐ IM ☐ IV	______ grams ______ mg/kg			#:________
Pre-Meds	**Route**	**Dose**	**Directions**	**Quantity**	**Refills**
☐ Acetaminophen	☐ PO	☐ 325mg ☐ 500mg ☐ __________	☐ Pre_Med: ______________ ☐ ______________	☐ w/ea. Infusion ☐ __________	#:________
☐ Diphenhydramine	☐ PO ☐ IM ☐ IV	☐ 25mg ☐ 50mg	☐ Pre_Med: ______________ ☐ PRN Reaction: __________	☐ w/ea. Infusion ☐ __________	#:________
☐ methylprednisone					
☐ Ondansetron					
☐ Reglan					
☐ Other					
Flush					
☐ Saline 10mL	☐ IV	☐ 3 mL ☐ 5 mL ☐ __________	☐ Before and after infusion ☐ ______________	☐ 1 month ☐ 3 months	#:________
☐ Heparin - 10 Units/ml ☐ Heparin - 100 Units/ml	☐ IV	☐ 3 mL ☐ 5 mL ☐ __________	☐ After infusion ☐ ______________	☐ 1 month ☐ 3 months	#:________
Anaphylaxis					
☐ Diphenhydramine	☐ IV ☐ PO ☐ IM	☐ 25mg ☐ 50mg ☐ __________	☐ Pre-Med: ______________ ☐ ______________	☐ W/ ea. Infusion ☐ __________	#:________
☐ Epinephrine	☐ IM ☐ SQ	☐ Adult 1:1000 0.3mL ☐ Peds 1:2000 0.3mL	☐ PRN Anaphylaxis ☐ Repeating Dose: __________	☐ Once ☐ __________	#:________
☐ Epipen (2 pack)	☐ IM ☐ SQ				#:________
☐ Other:					
Vascular Access method	☐ Peripheral	☐ Central	☐ Other ______________		

SIGNATURE

X ______________________________________ Date: ______________
Product Substitution Permitted

Fax completed form to: (800)-737-4920 . Thank you for using Cornerstone Pharmacy
Phone: 800-361-1260