vitalcare of AUBURN HILLS

**VITAL CARE OF AUBURN HILLS (0429)**
**Address:** 1532 N Opdyke Road, Suite 700
**City/State/Zip:** Auburn Hills, Michigan 48326

**IMMUNOGLOBULIN REFERRAL ORDER FORM**
**Phone:** (947) 886-4178
**Fax:** (947) 886-4655

**Essential Data** **To process the referral, please provide the following minimum information:**

- ☐ Patient demographic information
- ☐ Copy of insurance card (front and back)
- ☐ History and physical documentation (including documentation of infection history and diagnosis, recent hospitalizations)
- ☐ Recent medication list, IV access information, and home health agency if applicable
- ☐ Immunization challenge test results and titer values
- ☐ Recent BUN and creatinine results
- ☐ Serum Ig level, including IgA, IgG, and IgM along with a Ig1, Ig2, Ig3, Ig4 subclass report
- ☐ Any additional relevant clinical documentation (labs and tests)

## Patient Demographics

| | | | | |
|---|---|---|---|---|
| Last Name: | | First Name: | | SSN: |
| Date of Birth: | Sex: | Height (cm): | Weight (kg): | |
| Allergies: | | | | |
| Address: | | | | |
| City: | | State: | Zip: | |
| Home Phone: | | Mobile Phone: | | |
| Emergency Contact Name: | | Emergency Contact Phone: | | |

## Patient Insurance Information

| | |
|---|---|
| Primary Insurance Name: | Secondary Insurance Name: |
| Policy Holder Name: | Policy Holder Name: |
| Relation to Policy Holder: | Relation to Policy Holder: |
| Member ID: | Member ID: |
| Group ID: | Group ID: |

| Immune Deficiency Diagnosis | ICD-10 | Neuromuscular Diagnosis | ICD-10 |
|---|---|---|---|
| ☐ Common variable immunodeficiency (CVID) with predominant immunoregulatory T-cell disorders | D83.1 | ☐ Chronic inflammatory demyelinating polyneuritis | G61.81 |
| ☐ Combined immunodeficiency, unspecified | D81.9 | ☐ Guillain-Barre syndrome | G61.0 |
| ☐ Common variable immunodeficiency, unspecified | D83.9 | ☐ Multifocal motor neuropathy | G61.82 |
| ☐ Hereditary hypogammaglobulinemia | D80.0 | ☐ Myasthenia gravis | G70.0 |
| ☐ Immunodeficiency with increased immunoglobulin M (IgM) | D80.5 | ☐ Myasthenia gravis with (acute) exacerbation | G70.01 |
| ☐ Nonfamilial hypogammaglobulinemia | D80.1 | ☐ Other encephalitis and encephalomyelitis | G04.81 |
| ☐ Other combined immunodeficiencies | D81.89 | ☐ Other inflammatory polyneuropathies | G61.89 |
| ☐ Common variable immunodeficiency, unspecified | D83.9 | ☐ Multiple sclerosis | G35 |
| ☐ Bullous pemphigold | L12.0 | ☐ Stiff-man syndrome | G25.82 |
| ☐ Pemphigus, unspecified | L10.9 | **Other Diagnosis** | **ICD-10** |
| ☐ Severe combined immunodeficiency (SCID) with low or normal B-cell numbers | D81.2 | ☐ Immune thrombocytopenic purpura | D69.3 |
| ☐ Severe combined immunodeficiency (SCID) with low T-cell and B-cell numbers | D81.1 | ☐ Dermatopolymyositis, unspecified, organ involvement, unspecified | M33.90 |
| ☐ Selective deficiency of immunoglobulin G (IgG) subclasses | D80.3 | ☐ Polymyositis, organ involvement, unspecified | M33.20 |
| ☐ Antibody deficiency with near-normal immunoglobulins or with hyperimmunoglobulinemia | D80.6 | ☐ Other Common Variable Immunodeficiencies | D83.8 |
| ☐ Selective lupus erythematosus, unspecified | M32.9 | ☐ Other: | |
| ☐ Wiskott-Aldrich Syndrome | D82.0 | ☐ Other: | |

If unable to find diagnosis/ICD-10 code, please refer to ICD-10-CM (cdc.gov) for reference.

## Prescription*

| Medication | Ig Product | Directions |
|---|---|---|
| ☐ Intravenous Route (IVIG) | _____ | ☐ PHARMACY TO DOSE<br>☐ Dose: _____ **grams** IV Frequency _____<br>Duration: _____ doses or _____ weeks (max duration of 1 year)<br>☐ Dose: _____ **grams/kg** IV Frequency _____<br>Duration: _____ doses or _____ weeks (max duration of 1 year) |
| ☐ Subcutaneous Route (SCIG) | _____ | ☐ PHARMACY TO DOSE<br>☐ Dose: _____ **grams** SC Frequency _____<br>Duration: _____doses or _____weeks (max duration of 1 year)<br>☐ Dose: _____ **grams/kg** SC Frequency _____<br>Administer SCIG using _____ sites at a time<br>Duration: _____doses or _____weeks (max duration of 1 year) |

## Additional Management Orders*

| | |
|---|---|
| **Hydration Protocol:**<br>☐ Per Pharmacy Protocol<br>☐ Per Provider Protocol _____ | **Premedication Protocol**<br>☐ Per Pharmacy Protocol<br>☐ Per Provider Protocol _____ |
| **Anaphylaxis Protocol:**<br>☐ Per Pharmacy Protocol<br>☐ Per Provider Protocol _____ | **Flush Protocol:**<br>☐ Per Pharmacy Protocol<br>☐ Per Provider Protocol _____ |
| **Labs Protocol:**<br>☐ Per Pharmacy Protocol<br>☐ Per Provider Protocol _____ | Other: _____ |

**Product selection permitted unless dispense as written is checked or clearly written on order form.*
**Ig dose will be rounded to the nearest vial size*
**If order is not specified, it will be considered as a one-time order and must be rewritten.*

## Notes to Pharmacy

☐ First Dose to be given in home
☐ Skilled Nursing visits as required

## Referring Provider Information

| | | |
|---|---|---|
| Ordering Provider's Name: | | |
| NPI: | Specialty: | |
| Facility Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Office Phone: | Office Fax: | |
| Dispense as Written | | |
| Provider Signature: | | Date: |

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED