SCIG Infusion

OptiMed
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Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all of the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber: ______________________ **NPI:** ______________________

Phone: ______________ **Fax:** ______________ **Office Contact:** ______________

Address: ____

Patient Information

Name: ______________________ **DOB:** ______________ ☐**M** ☐**F**

Address: ____

Phone: ______________ **2nd Phone:** ______________ **SSN:** ______________

Primary Language: ______________ **Functional Limitations:** ______________

Clinical Information

Primary Diagnosis: ______________________ ICD-10 Code: ______________

Secondary Diagnosis: ______________________ ICD-10 Code: ______________

Weight: ________ ☐lb ☐kg **Height:** ________ ☐in **IgA deficiency:** ☐Yes ☐No If yes, IgA level: ______________

Allergies: ______________________________ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: ______________________________

Will this be the patient's first dose? ☐Yes ☐No, date of last dose: ________ Product given: ________ Dose given: ________

Site of care: Patient to be trained in the home by skilled nursing then transitioned to self-administration when clinically appropriate.

Additional Notes: ____

Prescription Information

☐ **Pharmacist to select IG product based on payer coverage and clinical appropriateness (select IG concentration desired below)**

☐ 10% product ☐ 20% product

☐ **Specific IG Product required (select desired product below)**

10% Products: ☐ Gammagard Liquid ☐ Gammaked ☐ Gamunex-C ☐ Hyqvia ☐ Other: ______________

20% Products: ☐ Cuvitru ☐ Hizentra ☐ Other: ______________

IG Dosing: ______________ **g/day for** ______________ **day(s) every** ______________ **weeks.**

Quantity (# of doses): ______________

Rate of Administration: ☐Pharmacist to determine based on manufacturer guidelines

☐Custom ____

PRN Medication(s):

☐Acetaminophen 325mg: 1-2 tablets PO Q4-6 hours prn (Do not exceed 4 doses/24 hours) Quantity: 120 Refills: PRN
☐Diphenhydramine 25mg: 1-2 tables PO Q4-6 hours prn (Do not exceed 4 doses/24 hours) Quantity: 120 Refills: PRN
☐Other PRN medication(s):____

Anaphylaxis Kit (to be provided to all patients):
Patient Instructions: Keep on hand at all times during SCIG administration. For allergic reaction, STOP infusion, call 911 immediately, and administer the following medications as instructed by the emergency operator:

- Diphenhydramine 25mg: 1-2 tablets PO (#2)
- Epinephrine auto-injector IM (#2): 0.3mg for patients > 30kg; 0.15mg for patients < 30kg

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.

Signature: ______________________________ **Date:**______________

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