US Bioservices
AmerisourceBergen

Immunoglobulin (PID) Referral Form

Phone: (866) 223-7485
Fax: (844) 810-6520

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date:_____

1. Patient Information

Last Name: _____ Home Phone:_____ Work/Mobile Phone:_____

First Name: _____ Home Address:_____

S.S. #:_____ Date of Birth:_____ City:_____ State:_____ Zip:_____

Guardian/Caregiver:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____ ☐ lbs. ☐ kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance:_____ Phone:_____ Prescription Card: _____ Phone:_____

Subscriber Name:_____ Policy #:_____ BIN/PCN:_____

Policy #:_____ Group #:_____ Medicare #:_____ Medicaid #:_____

3. Prescriber Information

Prescriber Name:_____ ☐ MD ☐ DO ☐ NP ☐ PA License #:_____ NPI #:_____ DEA #:_____

Practice Name: _____ Phone:_____ Fax:_____

Address:_____ Office Contact:_____ Phone:_____

City: _____ State:_____ Zip:_____ Collaborating Physician:_____

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Medical History: ☐ Renal insufficiency ☐ Thromboembolic event ☐ CHF ☐ Diabetes ☐ HTN ☐ Other:_____

Patient recieved IVIG previously? ☐ Yes ☐ No Lab orders:_____

Allergies:_____

IgG Level/Date:_____ IgA Level/Date:_____

- ☐ D80.0 Hereditary hypogammaglobulinemia
- ☐ D80.1* Nonfamilial hypogammaglobulinemia
- ☐ D80.5 Immunodeficiency with increased IgM
- ☐ D81.0 SCID with reticular dysgenesis
- ☐ D81.1 SCID with low T- and B-cells numbers
- ☐ D81.2 SCID with low or normal B-cell numbers
- ☐ D81.6 MHC class I deficiency
- ☐ D81.7 MHC class II deficiency
- ☐ D81.89 Other combined immunodeficiency
- ☐ D81.9 Combined immunodeficiency, unspecified
- ☐ D82.0 Wiskott-Aldrich syndrome
- ☐ D83.0 CVID with predominant abnormalities of B-cells
- ☐ D83.2 CVID with autoantibiodies to B- or T-cells
- ☐ D83.8 Other CVIDs
- ☐ D83.9 CVID, unspecified
- ☐ Other: _____

* Code not Medicare Part B approved

5. Prescription Information

Medication Orders	Brand	Therapy Regimen	Refills
☐ IVIG ☐ SCIG		Dose:_____ g/day x_____ days, every_____ weeks	
☐ IVIG ☐ SCIG		Dose: _____ g/kg/day x_____ days, every_____ weeks	

Pre-Meds:

- ☐ Tylenol® 500-1000 mg PO PRN
- ☐ Benadryl® 25-50 mg PO PRN
- ☐ IV Steroids:_____
- ☐ IV Hydration:_____
- ☐ Other:_____

- ☐ Anaphylaxis Kit:
  - Epinephrine IM/SC 1:1000-0.3mg UD PRN anaphylaxis reaction
  - Epinephrine injection, USP auto-injector IM/SC UD PRN anaphylaxis reaction
  - Diphenhydramine IV 50mg/ml UD PRN anaphylaxis reaction
  - NS IV 500ml UD PRN anaphylaxis reaction.
- ☐ Include 0.9 NaCl, Heparin 10-100 units/ml, and/or D5W flushes PRN to establish and maintain IV access
- ☐ Ramp infusion as directed by manufacturer as tolerated by patient
- ☐ Provide nurse for infusion of medication(s) ordered

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature _____ Date _____ / _____ / _____

Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. _____ Date _____ / _____ / _____

Prescriber Signature-Dispense as Written PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. _____ Date _____ / _____ / _____