US Bioservices
AmerisourceBergen

Immunoglobulin (AI) 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: _____ ☐ lb ☐ kg

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and 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 and 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 Neurological studies: _____

Allergies: _____

Platelet count / Date: _____

☐ D69.3 Immune Thrombocytopenic Purpura	☐ G61.0 Guillain-Barre Syndrome	☐ G70.01 Myasthenia Gravis with (acute) exacerbation
☐ G25.82 Stiff-man Syndrome	☐ G61.81 Chronic Inflammatory Demyelinating Polyneuritis	☐ L10.0 Pemphigus Vulgaris
☐ G35 Multiple Sclerosis	☐ G61.82 Multifocal Motor Neuropathy	☐ M33.20 Polymyositis, organ involvement unspecified
☐ G60.3 Idiopathic Progressive Neuropathy	☐ G70.00 Myasthenia Gravis without (acute) exacerbation	☐ M33.90 Dermatopolymyositis, organ involvement unspecified

☐ Other: _____

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 1:1000-0.3 mg UD PRN anaphylaxis reaction
- Epinephrine injection, USP auto-injector IM / SC UD PRN anaphylaxis reaction
- Diphenhydramine IV 50 mg/ml UD PRN anaphylaxis reaction
- NS IV 500 ml 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 ____ / ____ / ____