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: ________ ☐ 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 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 1:1000-0.3 mg 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 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 ____ / ____ / ____