Immunoglobulin—Auto Immune Disorder Referral Form

Phone 405.548.4848 **Toll Free** 888.848.4588 **Fax** 405.418.4442

PATIENT INFORMATION

Patient Name:		Date of Referral:	
Address:		SSN:	Gender:
City, State, Zip:		DOB:	Age:
Caregiver Name (if other):		Relationship:	Phone:
Emergency Contact:		Relationship:	Phone:
Primary Insurance Subscriber:		Primary Language:	
Policy #:	Group #:	Phone #:	
Insurance Phone:		Work Phone #:	

PRIMARY DIAGNOSIS

☐ L40.9 - Psoriasis
☐ M06.9 - Rheumatoid arthritis
☐ M05.00 - Felty's Syndrome
☐ M05.10 - Rheumatoid lung
☐ M45.9 - Ankylosing spondylitis
☐ L40.50 - Psoriactic arthropathy
☐ Other - Please indicate ICD10-CM code & description:_____

_____

_____

_____

Date of diagnosis or years with disease:_____

_____

MEDICAL HISTORY

Allergies: ☐ NKDA
☐ Yes, listed:_____

_____

Ht:_____ ☐ in ☐ cm
Wt:_____ ☐ lbs ☐ kg
Date Taken:_____

Other Medical History:
☐ Cardiac Disease ☐ Diabetic
☐ Renal Dysfunction
☐ Migraine
☐ Other:_____

_____

Access: ☐ Peripheral ☐ SQ
☐ **Port** ☐ _____

PRESCRIPTIONS & ORDERS

Is this the first dose? ☐ Yes ☐ No
If no, first dose given?_____
☐ Start ASAP
☐ First/next dose due? _____
Administer: ☐ Intravenous ☐ SQ
Product: ☐ Pharmacist to determine
OR ☐ _____
Dose:
☐ _____ gm/kg over _____ day(s). Repeat every _____ weeks(s) for _____ cycle(s)
☐ _____ mg/kg every _____ week(s) for _____ cycle(s)
☐ Other:_____

_____

Please attach and fax
1. Insurance card(s) and demographic information
2. Recent clinical assessment note or H&P
3. Current medication list

OTHER ORDERS

Premedication:
☐ Diphenhydramine (Benadryl®) ☐ 25mg or ☐ 50mg orally 30 mins before infusion
☐ Acetaminophen (Tylenol®) ☐ 500mg or ☐ 1000mg orally 15-30 mins before infusion
☐ Heparin 5000 units subcutaneously pre & post IG infusion
☐ None
☐ Other:_____

Lab Orders:
☐ BUN and Serum Creatinine
☐ With each infusion
☐ Other:_____

_____

☐ Immunofixation Immunoglobulins Quantitation
☐ Prior to first infusion
☐ After _____ infusion(s)

Adverse and Anaphylactic Reactions will be treated per OptionOne protocol.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.	**Signature:**_____
	Date:_____

PHYSICIAN INFORMATION

Name:		Hospital/Clinic:	
Address:		Office Contact:	
City, State, Zip:		Phone:	Fax:
NPI:	UPIN:	License #:	

Remicade Pediatric Infusion Reaction Protocol		
Type of reaction symptoms	**Treatment protocol**	**Prophylaxis**
MILD flushing, dizziness, headache, diaphoresis, nausea or palpitations	•Slow infusion rate to 10 mL/h •Infuse normal saline (250-500 mL/h) •Diphenhydramine 12.5-25 IV •Acetaminophen 325 mg po •Monitor VS every 10 min until WNL Wait 20 min, then increase infusion rate to 20 mL/h x 15 min, then 40 mL/h, 80 mL/h, 100 mL/h 125 mL/h every 15 min, as tolerated	•Pretreat with diphenhydramine 12.5 mg and acetaminophen 325 mg po 1.5h before infusion (5 days of a second-generation antihistamine can be substituted to decrease sedation) •Test dose at 10 mL/h x 15 min then increase to 20 mL/h, 40 mL/h, 80 mL/h, 100 mL/h, 125 mL/h every 15 min as tolerated
MODERATE chest discomfort, dyspensa, hypotension or hypertension (>20 mm Hg SBP), increased temperature, palpitation, or urticaria	•Stop infusion or slow infusion to 10 mL/h •Infuse normal saline (250-500 mL/h) •Diphenhydramine 12.5-25 mg IV •Acetaminophen 325 mg po •Monitor VS every 5 min until WNL •Wait 20 min then restart infusion at 10 mL/h for 15 min •Increase infusion rate to 20 mL/h x 15 min, then 40 mL/h, 80 mL/h, 100 mL/h 125 mL/h every 15 min, as tolerated	•Pretreat with diphenhydramine 12.5-25 and acetaminophen 325 mg po 1.5 hr before infusion (5 days of a second-generation antihistamine can be substituted to decrease sedation) •Test dose at 10 mL/h before x 15 min •Increase infusion rate to 20 mL/h, 40 mL/h, 80 mL/h, 100 mL/h 125 mL/h every 15 min, as tolerated
SEVERE hypotension or hypertension, increased temperature with rigors, dyspenea with wheezing, stridor, flushing	•Stop infusion •Epinephrine (1:1000) 0.1-0.5 mL SQ (may repeat every 5 min x 3) if wheezing present •Diphenhydramine 12.5-25 mg IV hydrocortisone 100 mg IV or methylpredinsolone 20-40 mg IV •Monitor VS every 2 min until WNL	•Prednisone 50 mg po every 12 h for three doses before infusion or hydrocortisone 100 mg IV or methylpredinsolone 20-40 mg IV before infusion •Pretreat with diphenhydramine 12.5-25 mg and acetaminophen 325 mg po 1.5 hr before infusion (5 days of a second-generation antihistamine can be substituted to decrease sedation) •Test dose at 10 mL/h before for 15 min •Increase infusion rate to 20 mL/h, 40 mL/h, 80 mL/h, 100 mL/h every 15 min, as tolerated
DELAYED rash or urticaria, myalgias, flu-like symptoms, joint stiffness and pain, headache	•Acetaminophen 325 mg po qid •Second-generation antihistamine or diphendydramine 12.5 mg po qd-bid methylprednisolone pack if sevee arthralgia	•Pretreat with diphenhydramine 12.5 mg and acetaminophen 325 mg po 1.5 h before infusion (5 days of a second-generation antihistamine can be substituted to decrease sedation •Test dose at 10 mL/h before for 15 min •Increase rate to infuse over 3 h •Acetaminophen 325-500 mg po qid for 3 d •Second-generation antihistamine for 7 d following infusion •Send home with methylprednisolone dose pack if severe joint pain