IVIG (Immune Globulin) Order/Referral Form

GAMMA THERAPEUTIC CENTER
Center for Neurological Disorders

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www.gtinfusions.com

Patient Information

Patient Name:	Patient DOB:

Referral Status

☐ New Referral ☐ Restart ☐ Medication/Order Change ☐ D/C

Diagnosis and ICD 10 Code

☐ Diagnosis: ICD 10 Code:

Required Documentation

☐ Patient demographics	☐ Clinical/Progress notes supporting primary diagnosis
☐ Copy of patient insurance card(s), front & back	☐ Labs and tests
☐ Tried and Failed therapies	☐ Current Medication List

Medication Orders

☐ 10% Immunoglobulin Solution: gm/kg and Patient Weight: kg

☐ 10% Immunoglobulin Solution: gm

Frequency: Duration:

Infusion Center to select IVIg product based on availability.
Infusion Center to dose based on adjusted body weight if required by payor.

Labs to be collected	Lab Frequency		
☐ CBC	☐ EVERY infusion	☐ Every OTHER infusion	☐ Other:
☐ CMP	☐ EVERY infusion	☐ Every OTHER infusion	☐ Other:
☐ IgG	☐ EVERY infusion	☐ Every OTHER infusion	☐ Other:
☐ Other:	☐ EVERY infusion	☐ Every OTHER infusion	☐ Other:

Notes (Additional Info)

Premedication, adverse and anaphylactic reactions will be treated per Gamma Therapeutic Center protocol.

Prescriber Information

Prescriber Name:		NPI #:
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:		Date: (Order is valid for one year)

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

Notify patient we will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.