IVIG - TRANSPLANT REFERRAL FORM

Owl Rexall Drug
837 W. Arrow Hwy, Glendora, CA
Phone: 626-962-1061
Fax: 626-962-1157
www.OwlRexall.com - infusion@owlrexall.com

Patient Information: please provide a copy of the patient's insurance card or information

Date:	**Patient name:**	**DOB:**	**Gender:** ☐ F ☐ M	**HT:**	**WT:**
Address:		**City:**	**State:**	**Zip Code:**	**Phone:**
Insurance:			**ID#:**		**Group #:**

Allergies: ☐ NKDA ☐ List allergies:

Clinical Information: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization

Diagnosis (ICD 10):
☐ Z94.0 Transplant, Kidney
☐ D89.89 Autoimmune disease, not elsewhere classified
☐ T86.10 Complications of transplant organ, Kidney
☐ B34.3 Polyoma viremia
☐ Other (specify): _____

Ht : _____ in Wt : _____ lb
* Patient demographic ,including insurance information
Labs- Most recent BUN/SCr and IgA level (H & P)

Treatment

RX: IVIG _____ grams daily for _____ Dose Given Over 6 Hours
Infusion Rate:_____cc/hr for the 1st hr _____cc/hr for the second hr _____cc/hr thereafter

Pre-Medication: ☐ Acetaminophen 650 mg po one time 30-60 min prior to each dose of IVIG
☐ Diphenhydramine 25 mg po one time prn 30-60 min prior to each dose of IVIG
☐ Other: _____

Pharmacist will round down to nearest vial and maintain at least 90% of calculated dose. If dose deviates by more than 10% of calculated dose, Pharmacist may round up to nearest vial.
☐Patient has been previously treated with IVIG and tolerated therapy ☐ Patient has NOT been previously treated with IVIG
☐ Pharmacist to use current weight for dose calculations ☐ Use (specify): _____ kg as dosing weight

Dose: _____ Frequency: _____ Start Date: _____ Duration: _____

Physician Information

Physician name:		**Phone:**	**Office contact:**	
Physician address:	**City:**		**State: CA**	**Zip:**
NPI:	**DEA:**	**Fax and/or Email:**		
Signature:		**Date:**	☐ **DO NOT SUBSTITUTE**	