

**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**

<b>Date:</b>	<b>Patient name:</b>	<b>DOB:</b>	<b>Gender:</b> <input type="checkbox"/> F <input type="checkbox"/> M	<b>HT:</b>	<b>WT:</b>
<b>Address:</b>		<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>	<b>Phone:</b>
<b>Insurance:</b>			<b>ID#:</b>	<b>Group #:</b>	
<b>Allergies:</b> <input type="checkbox"/> NKDA <input type="checkbox"/> 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	<b>Pre-Medication:</b> <input type="checkbox"/> Acetaminophen 650 mg po one time 30-60 min prior to each dose of IVIG <input type="checkbox"/> Diphenhydramine 25 mg po one time prn 30-60 min prior to each dose of IVIG <input type="checkbox"/> Other: _____
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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**

<b>Physician name:</b>		<b>Phone:</b>	<b>Office contact:</b>	
<b>Physician address:</b>		<b>City:</b>	<b>State:</b> CA	<b>Zip:</b>
<b>NPI:</b>	<b>DEA:</b>	<b>Fax and/or Email:</b>		
<b>Signature:</b>			<b>Date:</b>	<input type="checkbox"/> DO NOT SUBSTITUTE

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