ARJ Infusion SERVICES *Specialty Pharmacy & High-Tech Nursing*

FAX completed form to ARJ (877) 451-8955
Intake Specialist (866) 451-8804
referral@arjinfusion.com
arjinfusion.com/referrals

Adult Subcutaneous Immune Globulin (SCIG) Patient Referral Form

Patient Name: _____ **Date:** _____

SSN#: _____ DOB: _____ Primary Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Diagnosis:

279.02 Selective IgM Immunodeficiency
- ☐ D80.4 Selective Deficiency Immunoglobulin M (IgM)

279.03 Selective IgG Immunodeficiency
- ☐ D80.3 Selective deficiency of immunoglobulin G (IgG) subclasses

279.04 Congenital Hypogammaglobulinemia
- ☐ D80.0 Hereditary Hypogammaglobulinemia

279.05 Immunodeficiency with increased IgM
- ☐ D80.5 Immunodeficiency with increased Immunoglobulin M (IgM)

279.06 Common variable immunodeficiency (CVID)
- ☐ D83.0 Common variable immunodeficiency with predominate abnormalities of B-cell numbers and functions
- ☐ D83.2 Common variable immunodeficiency with autoantibodies to B or T cells

279.06 Common variable immunodeficiency (CVID) *cont.*
- ☐ D83.8 Other common variable immunodeficiency
- ☐ D83.9 Common variable immunodeficiency, unspecified

☐ **Other ICD-10:** ***SEE REVERSE SIDE FOR MORE ICD-10 CODES***

_____

1 Patient Information:

☐ NKDA Allergies: _____

Ht: _____ in/cm Wt: _____ lbs/kg Male ☐ Female ☐

Is this the first dose: Yes ☐ No ☐

If no, list product: _____

Date of last infusion: _____ Next dose due: _____

Attach documents to FAX *(see below)*

- ☒ Copy of insurance card
- ☒ Patient demographics, to include insurance information
- ☒ Labs to include IgA level
- ☒ H&P
- ☒ For Immune deficiency: Detailed infection history, baseline IgG levels (including subclasses), immune response to vaccinations (including report)

Other: _____

2 Clinical Information: *ARJ policies and protocols to be provided upon request.*

Medication	Dose	Directions	Quantity/Refills
☐ Preferred Product: _____ ☐ No Preference	_____ grams **OR** _____ gm per kg (rounded to the nearest vial size) _____ day(s) every week **OR** _____ every _____ week(s)	Infuse per manufacturer guidelines subcutaneously in _____ sites over _____ hours via infusion pump as tolerated.	Dispense: 1 month supply on all selected medications. Refill x12 months unless otherwise noted. ☐ *Other:* _____

Premedication take 30 minutes prior to infusion *(Note: If nothing is checked, no premeds will be given)*
- ☐ Diphenhydramine 25 - 50 mg po x1 dose
- ☐ Acetaminophen 325 - 650 mg po x1 dose
- ☐ Other: _____

Medications to be used as needed:
- ☐ Lidocaine 2.5% cream and Prilocaine 2.5% topically: Apply to needle insertion site prior to access PRN
- ☐ Diphenhydramine 25-50 mg po every 4-6 hours as needed for chills, headache, rash/itching (maximum 400 mg/per day)
- ☐ Acetaminophen 325-650 mg po every 4-6 hours as needed for fever, headache or chills (maximum 3000 mg/per day)

☒ **Skilled Nursing** services to be provided for infusion, assessment and teaching as needed.

Adverse reaction medications: *Dispense 1 dose of each medication below to keep at patient home.*
- ☒ **Epinephrine** pen by weight for use IM or SQ PRN in anaphylactic reaction; may repeat one time.
- ☒ **Diphenhydramine** 25-50 mg po for allergic reaction/ anaphylaxis.

☐ Other Instructions: _____

3 Prescriber Information: *By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.*

Physician Name: _____ Office Contact: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

License #: _____ DEA#: _____ NPI #: _____

_____ Date: _____ | _____ Date: _____

Physician Signature Required - Substitution Permitted ***Physician Signature Required - Dispense as Written***

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ICD-10

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- ☐ D83.8 Other common variable immunodeficiency
- ☐ D83.9 Common variable immunodeficiency, unspecified

279.12 Wiskott-Aldrich syndrome

- ☐ D82.0 Wiskott-Aldrich syndrome

279.2 Severe Combined Immunodeficiency

- ☐ D81.0 Severe combined immunodeficiency with reticular dysgenesis
- ☐ D81.1 Severe combined immunodeficiency with low T and B cell numbers
- ☐ D81.2 Severe combined immunodeficiency with low or normal B cell numbers
- ☐ D81.6 Major Histocompatibility complex class I deficiency
- ☐ D81.7 Major Histocompatibility complex class II deficiency
- ☐ D81.89 Other combined immunodeficiency
- ☐ D81.9 combined immunodeficiency, unspecified

☐ Other: _____

_____

_____

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