Ig Referral Form

Fax completed form to: 833-871-9247

Patient Information

Patient Name: | Date of Birth: | ☐ Male ☐ Female

Address: | City: | State: | Zip:

Home Phone: | Other Phone: | SSN:

Height: | Weight: | Allergies:

Insurance Information

Primary Ins.:	Group #:	Secondary Ins:	Group #:
Card Holder:	ID #:	Card Holder:	ID #:
Employer:	Phone:	Employer:	Phone:

PBM Information

Rx Card (PBM):	PBM BIN#:	Group #:
City:	State:	Phone:

Diagnosis and Statement of Medical Necessity

Immunology Ig Level: Date:

- ☐ D80.0 Hereditary Hypogammaglobulinemia
- ☐ D80.5 Immunodeficiency w/Increased IgM
- ☐ D83.2 CVID w/aAbs to B or T-Cells
- ☐ D83.0 CVID w/Predominant Abnormalities of B-Cell # & function
- ☐ D81.89 Other CID
- ☐ D81.9 CID, unspecified
- ☐ D82.0 Wiskott-Aldrich Syndrome
- ☐ D83.8 Other CVID
- ☐ D83.9 CVID, unspecified
- ☐ D81.6 MHC Class I Deficiency
- ☐ D81.7 MHC Class II Deficiency
- ☐ Other____________________

Neurology/Other

- ☐ G61.81 CIDP
- ☐ D69.3 ITP
- ☐ G35 Multiple Sclerosis
- ☐ G61.0 Guillain-Barre Syndrome
- ☐ G70.00 Myasthenia Gravis w/o exacerbation
- ☐ G70.01 Myasthenia Gravis w/ exacerbation
- ☐ M33.2 Polymyositis
- ☐ M33.20 Polymyositis w/organ involvement
- ☐ M33.21 Polymyositis w/respiratory
- ☐ M33.22 Polymyositis w/myopathy
- ☐ Other____________________

Prescription Information

all supplies including syringes and needles will be dispensed if needed

Rx	Dose	Directions		Refills
☐ **Intravenous Ig (IVIg)**	☐ Ig Product: RPh to Recommend ☐ Ig Product: ☐ Do Not Substitute	________ grams/kg IV over ______ days every ________ days	☐ Peripheral IV Access ☐ Other (please indicate): First Dose: ☐ Yes ☐ No	☐ x 1 year ☐ ________ months
	☐ D5W flush with 5-10 ml IV pre and post infusion		☐ NS flush with 5-10 ml IV pre and post infusion	
	☐ Heparin _____ units/ml - 2-5 ml flush after D5W/NS			
☐ **Subcutaneous Ig (SCIg)**	☐ Ig Product: RPh to Recommend or Other ________________ First Dose: ☐ Yes ☐ No	__________ grams SC every ______________ days		☐ x 1 year ☐ ________ months
	☐ EMLA Cream (30 grams) topically - Use as Directed			☐ x1 year ☐ _____ months

Anaphylaxis Kit

- ☐ EpiPen 0.3mg IM 2-pak - Use as Directed Refills: ___________ OR ☐ EpiPen Jr. 0.15mg IM 2-pak - Use as Directed Refills: ___________
- ☐ Epinephrine vial 1:1000 IM x1 dose Refills: ___________
- ☐ Diphenhydramine_____mg po x2 doses OR ☐ Diphenhydramine_______ mg IM x1 dose
- ☐ Acetaminophen_____mg po x 1 dose

Other Medications

Drug:	Refills:	Drug:	Refills:
Sig:		Sig:	

Additional Instructions

Skilled Nursing visits as required? ☐ Yes ☐ No Ship to: ☐ Patient ☐ Physician

☐ Standard supplies as needed ☐ Ig trough in _____ month(s) ☐ Other lab orders:

Physician Information

Physician Name:	Lic. #:	DEA #:	
Practice Name:	NPI #:	Specialty:	
Address:	City:	State:	Zip:
Nurse Contact:	Phone:	Fax:	
Physician Signature:		Date:	

By signing this form and utilizing our services, you are authorizing Mosaic and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Important Notice: This transmission may contain confidential health information that is legally protected. As you are obligated to maintain it in a safe and confidential manner, unauthorized re-disclosure or a failure to maintain confidentiality of the information contained herein could subject you to penalties under state and federal law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination or copying of this communication is strictly prohibited.

Please include all lab results and list of concurrent medications.