



Cytogam Referral Form

BIOMED Pharmaceuticals

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Corporate Office 1512 8th Ave. Suite 100 Fort Worth, TX 76104	Desoto 2727 Bolton Boone Dr. Ste 110 Desoto, TX 75115	Houston 1919 N. Loop West, Ste 180 Houston, TX 77008	Tyler 837 S. Fleishel Tyler, TX 75701	San Antonio 211 North San Saba, Suite 205 San Antonio, TX 78207
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Name: _____ Date of Birth: _____ SS#: _____
 Parent or Guardian: _____ Home Phone: _____ Work Phone: _____
 Address: _____ City: _____ St. _____ Zip _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____ Male ___ Female ___
 Emergency Contact Name _____ Relationship _____
 Emergency Contact Phone # _____ Primary Language _____

Primary Insurance: _____ Phone #: _____ Subscriber: _____ DOB: _____ ID#: _____ Policy/Group #: _____ Employer: _____	Secondary Insurance: _____ Phone #: _____ Subscriber: _____ DOB: _____ ID#: _____ Policy/Group #: _____ Employer: _____
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Prescription Drug Card: Name _____ Group# _____ ID# _____

Diagnosis:
 ___ Diagnosis Code _____ Complicating Factors: _____
 Has Patient had IVIG before? If so, what brand? _____
 Is the Patient Currently on any medications? ___yes ___no
 List medications: _____
 Allergies: _____ Patient Weight: _____

Prescription:
 Cytogam ___-150mg/kg ___-100mg/kg ___-50mg/kg IV titrate per manufacturer's protocol

Premedication Orders: _____

Repeat Cytogam: _____
 Other: _____

___ Anaphylaxis kit per protocol* see below
 ___ Start PIV as required for administration in Infusion Center
 ___ 5-10 ml for flush as needed NS

Other: _____

*Anaphylaxis order:
 Benadryl 50 mg/IV 25 mg/min (dose 1-2 mg/kg-max 300 mg); Solumedrol 125 mg IV (dose 4-8 mg/kg max 400 mg); Epinephrine 1:1000 (1 mg/ml) 0.3 ml IM or SQ (0.01 ml/kg/dose max 0.3 ml) may repeat 5-10 min.

Physician Certification: _____ TPI # _____ UPIN# _____ Tax ID# _____
 Signature: _____ Date _____
 Print Name: _____ DEA # _____ NPI# _____
 Address: _____ City _____ State _____ Zip _____
 Phone: _____ Fax: _____ **Thank you for your referral.**