



IVIG Referral Form

BIOMED Pharmaceuticals

Phone: (817) 923-4495

Toll Free: (866) 923-4495

Intake Fax: (866) 923-4492

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

Name: _____ Date of Birth: _____ SS#: _____

Parent or Guardian: _____

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: _____

Prescription Drug Card: Name _____ Group# _____ ID# _____

Diagnosis:

- 279.2 Severe combined deficiency
- 279.3 Immunodeficiency
- 279.06 Common Variable Immunodeficiency
- 780.71 Chronic Fatigue Syndrome
- 340.0 Multiple Sclerosis

Other: _____

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:

IVIG _____ gms IV titrate per manufacturer's protocol Brand Name if desired: _____

Premedication Orders:

Repeat IVIG: _____
Other: _____

- Anaphylaxis kit per protocol* see below
- Start PIV as required for administration in Infusion Center
- 5-10 ml D5W for flush as needed
- IV to Heplock with 2-3 ml Heparin 10 units/ml

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.



Please send front and back copies of all insurance cards with referral.