VEROS HEALTH
Excellence in Complex Care

www.verosbiologics.com
Phone: 833.544.7979

Autoimmune Referral Form

Please complete the following and fax with clinical documentation to: **844.544.7979**

REFERRAL PROCESS

1. PATIENT INFORMATION			2. PHYSICIAN INFORMATION		
Name:			Physician's name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Home Phone:	Other Phone:		Office Contact:		
Email:	DOB:		Phone:	Fax:	
Gender: ☐ M ☐ F	Height:	Weight:	NPI:		

Allergies: _____

3. DIAGNOSIS Year of diagnosis: _____

- ☐ CIDP (G61.81)
- ☐ Dermatopolymyositis (prev. known as Dermatomyositis) (M33.10)
- ☐ Guillain Barré Syndrome (G61.0)
- ☐ Multifocal Motor Neuropathy (G61.82)
- ☐ Multiple Sclerosis (MS Relapsing/Remitting) (G35)
- ☐ Myasthenia Gravis w/o acute exac. (G70.00)
- ☐ Myasthenia Gravis with acute exac. (G70.01)
- ☐ Polymyositis (M33.20)
- ☐ Stiff Person Syndrome (G25.82)
- ☐ Other: _____

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. ADDITIONAL INFORMATION REQUESTED

Previous IG received: _____ Last infusion date: _____

Last BUN/SCR _____ ☐ H&P ☐ Nerve Conduction Study results/velocities ☐ Biopsy Results ☐ EMG Results ☐ CSF Results

☐ Other: _____

6. PRESCRIPTION INFORMATION Anticipated Start Date: _____

Immune Globulin Product: _____ ☐ IV ☐ SQ

Administer _____ grams daily for _____ day(s) OR _____ grams/kilogram daily over _____ day(s)

Repeat course every _____ week(s) for a total of _____ courses/cycles

☐ Pre-hydrate with: ☐ NS ☐ D5W ☐ Other: _____ _____ ml IV over _____ hours

☐ Pre medicate:

- ☐ Acetaminophen 325-650mg PO prior to IG and then Q4-6 hours as needed during infusion
- ☐ Diphenhydramine 25-50 mg PO prior to IG
- ☐ Other premedication: _____

☐ Post-hydrate with: ☐ NS ☐ D5W ☐ Other: _____ _____ ml IV over _____ hours

Provide supplies necessary to maintain IV Access: ☐ PIV ☐ Midline/PICC ☐ Port Administration method: ☐ Pump ☐ Dial-a-flow

7. FLUSH ORDERS

PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated
☐ Heparin 10 unit/ml ☐ Heparin 100 unit/ml

Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml. (Use Heparin 10 unit/ml for patients <2 years old)

8. ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.

Pediatrics: administer by age: *For mild reaction (rash/hives) give diphenhydramine*
Age 1-5: 12.5ml IV/PO x1 **Age 6-11**: 25mg IV/PO x1 **Age 12+:** 50mg IV/PO x1

For severe reaction (airway closure) administer epinephrine. 0.01mg/kg/dose (max 0.3mg) SubQ/IM x 1.
If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs.

☐ Other: _____

9. NURSING ORDERS

Skilled nursing to insert, maintain and remove/de-access vascular access daily, weekly and/or as needed, draw labs as ordered, conduct patient assessments, and educate patient/caregiver on home infusion, medication administration, self-monitoring, and patient safety.

10. ☐ Dispense as written ☐ Substitution Permitted

PHYSICIAN'S SIGNATURE (required): _____ **Date:** _____

Prescription is valid for one year unless otherwise indicated.
The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.