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O: 901.316.5752 TP: 855.344.8724 F: 901.316.5760 TF: 844.588.5560
beneverepharmacy.com

TODAY'S DATE: ____________

☐ NEW PATIENT ☐ CURRENT PATIENT

Intravenous Immunoglobulin Referral Form

PATIENT INFORMATION

Patient Name ____________

Address ____________

City ____________ State ________ Zip ________

Home Phone ____________ Cell ____________

DOB ____________ SSN ____________

Drug Allergies ____________ ☐ Male ☐ Female

Patient Weight: ____________ Height: ____________

PRESCRIBER INFORMATION

Prescriber Name ____________ DEA# ____________

NPI# ____________ Tax ID ____________

Practice Name ____________

Address ____________ Suite ________

City ____________ State ________ Zip ________

Office Phone ____________ Fax ____________

Office Contact ____________

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance ____________

Policy # ____________ Group ________

Insurance Phone ____________

Prescription Drug Coverage: Company ____________

Secondary Insurance (if applicable) ____________

Policy # ____________ Group ________

Insurance Phone ____________

Phone ____________

RXGRP# ____________ RXBIN# ____________ PCN/ID# *(if available)* ____________

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE AND PRESCRIPTION BENEFIT CARDS IF AVAILABLE

CLINICAL INFORMATION

Diagnosis (ICD-10 Code): ____________ Date Diagnosed: ____________

Labs: IgG Level: ____________ PLT Level: ____________ Other: ____________

New to therapy: ☐ Yes ☐ No If no, date therapy began: ____________ Date of last dose: ____________

Previous Treatment (reason for discontinuation): ____________

Method of Administration: ☐ PIC ☐ Port ☐ IV Catheter Infusion via: ☐ Gravity ☐ Infusion Pump

PLEASE ATTACH A LIST OF PATIENTS'S CURRENT MEDICATIONS.

MEDICATIONS

☐ BIVIGAM	☐ Gammaplex 5%
☐ Carimune NF	☐ Gamunex 10%
☐ Flebogamma DIF ☐ 5% ☐ 10%	☐ Gamunex–C 10%
☐ Gammagard Liquid 10%	☐ OCTAGAM 5%
☐ Gammagard S/D	☐ Privigen 10%
☐ Other: ____________	

- ☐ 0.9% sodium chloride 5-10mL pre/post infusion and PRN
- ☐ Benadryl 25 – 50 mg infusion; dispense 2 doses
- ☑ Dispense Anaphylaxis Kit (weight/age based dosing per pharmacist)
- ☐ Heparin 10 Units/mL 5mL post infusion and PRN
- ☐ Heparin 100 Units/mL 5mL post infusion and PRN
- ☐ Sharps Container
- ☐ Standard supplies for administration as requested
- ☐ Tylenol 650 – 1,000 mg infusion; dispense 2 doses
- ☐ Other ____________

PRESCRIPTION INFORMATION

☐ Dose: ____________ grams/kg/day x ________ days ☐ Dose: ____________ grams/day x ________ days

Frequency: ____________ Refills: ____________ Goal of therapy: ____________

Specific infusion parameters, if applicable: ____________

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

Prescriber's Signature (signature required. NO STAMPS) ____________ Date ____________

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