QiVIGY

Immune Globulin Intravenous (Human) 10% Liquid

Referral Form

Date:

BARNES HEALTHCARE SERVICES

PATIENT INFORMATION

Patient name: DOB:

Address:

City, State, Zip:

Gender: ☐ F ☐ M Height: Weight: ☐ lb ☐ kg

Preferred phone: Last 4 of SSN:

Allergies:

QIVIGY PRESCRIPTION INFORMATION

Diagnosis: ICD-10:

Dose: mg/kg IV or mL/kg IV every weeks

(Recommended dosing is 300-800 mg/kg or 3-8 mL/kg every 3-4 weeks, for first and later infusions, per QIVIGY Prescribing Information)

☐ IV rate (first infusion): Begin IV infusion at 1 mg/kg/min (0.01 mL/kg/min) for 30 min and then increase gradually every 30 min to a maximum rate of 8 mg/kg/min (0.08 mL/kg/min) as tolerated, per QIVIGY Prescribing Information

☐ IV rate (second or later infusion): Begin IV infusion at 2 mg/kg/min (0.02 mL/kg/min) for 15 min and then increase gradually every 15 min to a maximum rate of 8 mg/kg/min (0.08 mL/kg/min) as tolerated, per QIVIGY Prescribing Information

☐ IV rate: Start at mL/kg/min, then increase by mL/kg/min every min to maximum rate of mL/kg/min

☐ Pharmacy to determine infusion rate

# of refills: Anticipated start date:

INSURANCE INFORMATION

Primary insurance:

Member ID: Group #:

Policy holder: Relationship:

Secondary insurance:

Member ID: Group #:

Policy holder: Relationship:

PROVIDER INFORMATION

Provider name: Specialty:

Office Contact:

Provider address: Phone:

City, State, Zip: Fax:

License #: DEA #: NPI #:

☐ DISPENSE QIVIGY AS WRITTEN

Provider signature: Date:

SEND COMPLETED REFERRAL TO BARNES HEALTHCARE SERVICES

Fax: 888-276-7948 | Email: tcchit@barneshc.com | Referral Phone: 800-292-6800

Please see accompanying Full Prescribing Information for complete prescribing details.