Your Health, True Wealth

Infectious & Autoimmune Encephalitis (IAE) - Neuroinflammatory Disorders Referral Form

Please complete and fax the referral for mto
f: 818-882-8929

PATIENT INFORMATION

Patient Name Address		DOB	Contact Phone
Gender	City	State	Zip
☐M ☐F	Social Security, last 4 digits	Weight (lb.)	Height (in.)

PRESCRIBER INFORMATION

Ordering Prescriber Practice		Prescriber NPI	
Name		Phone	Fax
Practice Address	City	State	Zip

ICD 10 DIAGNOSTIC CODES AND DESCRIPTIONS (include all that apply)

ICD 10 Code	Description

REQUIRED DOCUMENTATION

☐Insurance Cards ☐HPI and Clinical Encounter Notes (if applicable, the 3 most recent) ☐Most Recent Labs ☐Medication List

ADDITIONAL INFORMATION (if Available from the Patient's Medical History)

Supportive Diagnostic Testing

☐CSF testing ☐CT (chest, abdomen, pelvis, paranasal sinus) ☐ECG ☐EEG

☐MRI ☐PET or SPECT ☐PSG (Polysomnography)

Blood Tests

☐ Antinuclear Antibody Panel (ANA)	☐ Immunoglobulin Quantitative: IgG, IgA, IgM
☐ Anti-Streptolysin O (ASO)	☐ Lymphocyte subset panel (both absolute and percentages) CD3, CD4, CD8, CD19 and CD56
☐ Autoimmune Brain Panel (formally known as the Cunningham Panel)	☐ Serologic testing for infectious causes (Bacteria, Viruses, Parasites)
☐ CBC, CMP	☐ Serum testing for antibodies associated with autoimmune encephalitis
☐ Erythrocyte Sedimentation Rate (ESR), C-reactive protein, Ferritin	☐ Streptococcus Pneumonia Antibody
☐ Immunoglobulin (IgG) subclass panel (1-4)	☐ Thyroid peroxidase (TPO) and Thyroglobulin (Tg) Antibody test
☐ Neurocognitive Tests	
☐ Assessments, Scales, Questionnaires	
☐ Other	

Your Health, True Wealth

TREATMENT PLAN

IMMUNOGLOBULIN

SoleoHealthwillselectthe product based on clinical indication, product availability and payor requirements.

Administration Route ☐IV ☐SCIG ☐ Allow rounding to the nearest 5 gram vial size

Loading gm/kg x days

Maintenance gm/kg x days, every weeks

OTHER TREATMENTS

Include dosage, brand preference, frequency, and any other special instructions

PREMEDICATION

- ☐ NaCL 0.9% (IV prior to IG)
- ☐ NaCL 0.9% (IV post IG)
- ☐ Dexamethasone IV
- ☐ Methylprednisolone IV

Dispense as written Substitution Permitted

- ☐ Emla cream (or generic equivalent) PRN for peripheral IV or port
- ☐ Ondansetron, orally disengaging tablet (ODT)
- ☐ OTHER:

NURSING

Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on home infusion, medication administration, self-monitoring and safety.

I authorize the above patient treatment and Northridge Pharmacy Specialty & Infusion to serve as my agent when investigating and seeking approval of coverage and benefits for the Patient's services included in this form, including all site of service options and patient financial responsibility amounts. Such information may be provided to Northridge Pharmacy Specialty & Infusion at fax: 818-882-8929

Prescriber Name (Print) _____ Prescriber Signature _____ Date _____