

## PATIENT INFORMATION (Complete or fax existing chart)      PRESCRIBER INFORMATION

Patient Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ 2 <sup>nd</sup> Phone: _____ DOB: _____ Gender: M F Last 4 S.S: _____ Weight: _____ Ht: _____ Allergies: _____	Prescriber Name: _____ State License: _____ NPI #: _____ DEA: _____ Phone: _____ Address: _____ Fax: _____ City, State, Zip: _____ Contact Person: _____ Phone: _____
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## INSURANCE INFORMATION - INSTEAD - just send us a copy of the patients prescription / insurance cards (front & back)

Primary Insurance: _____ City, State, Zip: _____ Plan #: _____ Group #: _____ Phone: _____	RX Card (PBM): _____ BIN: _____ PCN: _____ City, State, Zip: _____ Group #: _____ Phone: _____
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## DIAGNOSIS / CLINICAL INFORMATION

<input type="checkbox"/> D80.0 Congenital Hypogammaglobinemia	<input type="checkbox"/> D81.9 SCID (unspecified)	<input type="checkbox"/> D83.9 Common Variable Immunodeficiency
<input type="checkbox"/> G35 MS (Relapsing Remitting)	<input type="checkbox"/> G61.0 GBS	<input type="checkbox"/> G61.81 CIDP
<input type="checkbox"/> G61.89 MMN	<input type="checkbox"/> G70.01 MG W/ acute exacerbation	<input type="checkbox"/> M33.20 Polymyositis
<input type="checkbox"/> M33.90 Dermatomyositis		
<input type="checkbox"/> Other Code: _____	Description: _____	

Needs by Date: \_\_\_\_\_ Ship to: Patient Office Other: \_\_\_\_\_  
 Lab Orders: \_\_\_\_\_

## PRESCRIPTION / ADMINISTRATION

Medication	Route	Dose	Directions	Refills	
Immune Globulin Brand (any): <input type="checkbox"/> Dispense As Written	<input type="checkbox"/> SC <input type="checkbox"/> IM <input type="checkbox"/> IV	_____ grams _____ mg/kg	IV or Sub - ___gm once daily for ___ days Repeat every ___ weeks for total of ___ Course/Courses	#: _____	
Pre-Meds	Route	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> _____	<input type="checkbox"/> Pre_Med: _____ <input type="checkbox"/> _____	<input type="checkbox"/> w/ea. Infusion <input type="checkbox"/> _____	#: _____
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> PO <input type="checkbox"/> IM <input type="checkbox"/> IV	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	<input type="checkbox"/> Pre_Med: _____ <input type="checkbox"/> PRN Reaction: _____	<input type="checkbox"/> w/ea. Infusion <input type="checkbox"/> _____	#: _____
<input type="checkbox"/> Methylprednisone					
<input type="checkbox"/> Ondansetron					
<input type="checkbox"/> Reglan <input type="checkbox"/> Zofran					
<input type="checkbox"/> Other					
Flush					
<input type="checkbox"/> Saline 10mL	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> Before and after infusion <input type="checkbox"/> _____	<input type="checkbox"/> w/ea. Infusion <input type="checkbox"/> _____	#: _____
<input type="checkbox"/> Heparin - 10 Units/ml <input type="checkbox"/> Heparin - 100 Units/ml	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> After infusion <input type="checkbox"/> _____	<input type="checkbox"/> w/ea. Infusion <input type="checkbox"/> _____	#: _____
Anaphylaxis					
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> IV <input type="checkbox"/> PO <input type="checkbox"/> IM	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> _____	<input type="checkbox"/> W/ ea. Infusion <input type="checkbox"/> _____	#: _____
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> IM <input type="checkbox"/> SQ	<input type="checkbox"/> Adult 1:1000 0.3mL <input type="checkbox"/> Peds1:2000 0.3mL	<input type="checkbox"/> PRN Anaphylaxis <input type="checkbox"/> Repeating Dose: _____	<input type="checkbox"/> Once <input type="checkbox"/> _____	#: _____
<input type="checkbox"/> Epipen (2 pack)	<input type="checkbox"/> IM <input type="checkbox"/> SQ				#: _____
<input type="checkbox"/> Other:					
Vascular Access method	<input type="checkbox"/> Peripheral <input type="checkbox"/> Central <input type="checkbox"/> Other _____				

## SIGNATURE

X \_\_\_\_\_ Date: \_\_\_\_\_  
 Product Substitution Permitted