IMMUNE GLOBULIN®

Please Fax Completed Form To: **800-783-9146**

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ DEA: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: ☐M ☐F Weight: _____(lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

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

CLINICAL INFORMATION

☐ D80.0 Congenital Hypogammaglobinemia	☐D81.9 SCID (unspecified)
☐ G35 MS (Relapsing Remitting)	☐G61.0 GBS
☐ G61.89 MMN	☐G70.01 MG W/ acute exacerbation
☐ M33.90 Dermatomyositis	☐D83.9 Common Variable Immunodeficiency
☐ Other Code: Description:	☐M33.20 Polymyositis

Needs by date: Ship to: ☐ Patient ☐ Office ☐ Other: _____

(DRUG NAME) ORDERS – this section may not be needed)

Medication	Route	Dose	Directions	Quantity	Refills
Immune Globulin Brand (any): ☐ Dispense as written	☐ IV ☐ SC ☐ IM	_____grams _____g/kg	IV or Sub - _____gm once daily for _____days Repeat every _week for total of _____Course/Courses		
Pre- Medications	**Route**	**Dose**	**Directions**	**Quantity**	**Refills**
☐ Acetaminophen	☐ PO	☐325 mg ☐500 mg ☐_____mg	☐Pre-Med: _____ ☐ _____	☐ w/ ea. Infusion	
☐ Diphenhydramine	☐ PO ☐IM ☐IV	☐ 25 mg ☐ 50 mg	☐Pre-Med: _____ ☐PRN Reaction: _____	☐ w/ ea. Infusion	
☐ Methylprednisone					
☐ Odansetron					
☐ Reglan					
☐ Other					
Flush	**Route**	**Dose**	**Directions**	**Quantity**	**Refills**
☐ Saline 10mL	☐ IV	☐ 3mL ☐ 5 mL ☐_____	☐ Before and after infusion ☐_____	☐w/ ea. Infusion	
☐ Heparin 10 units/mL ☐ Heparin 100 units/mL	☐ IV	☐ 3mL ☐ 5 mL ☐_____	☐ After infusion ☐_____	☐w/ ea. Infusion	
Anaphylaxis	**Route**	**Dose**	**Directions**	**Quantity**	**Refills**
☐ Diphenhydramine	☐ IV ☐PO ☐IM	☐ 25 mg ☐ 50 mg ☐_____	☐ Pre-med: _____ ☐ _____	☐ w/ ea. Infusion ☐	
☐ Epinephrine	☐ IM ☐ SQ	☐ Adult: 1:1000 0.3 mL ☐ Peds 1:2000 0.3 mL	☐ PRN Anaphylaxis ☐ Repeating Dose: _____	☐ Once ☐	
☐ EpiPen (2 pack)	☐ IM ☐ SQ				
☐ Other					

Vascular Access Method: ☐ Peripheral ☐ Central ☐Other_____

SIGNATURE

X_____ Date: _____

Prescriber Signature