



Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)			PRESCRIBER INFORMATION		
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____ Allergies: _____			Prescriber Name: _____ State License: _____ NPI #: _____ Tax ID: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____		
INSURANCE INFORMATION –AND – Send a copy of the patient’s prescription/insurance cards (front & back)					
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____			Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		
CLINICAL INFORMATION					
☐ D80 Immunodeficiency with predominantly antibody defects	☐ D80.1 Nonfamilial hypogammaglobulinemia	☐ D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses	☐ D83.9 Common variable immunodeficiency (unspecified)		
☐ G61.0 Guillain-Barré Syndrome	☐ G61.81 CIDP	☐ G70.00 Myasthenia gravis	☐ G70.01 Myasthenia Gravis with (acute) exacerbation		
☐ M33.2 Polymyositis	☐ M33.90 Dermatomyositis	☐ M33.10 Other dermatomyositis, organ involvement unspecified	☐ Other: _____		
Vascular access: ☐ Peripheral ☐ Central ☐ Port Infusion method: ☐ Gravity ☐ Pump					
Adverse Reactions with Previous IG treatments? ☐ No ☐ Yes Reason/Brand: _____					
Obtain the following labs at prior to start of treatment and at _____ frequency: ☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ LFTs ☐ X-Ray ☐ Other: _____					
TRIED AND/OR FAILED MEDICATIONS		LEGNTH OF THERAPY		REASON FOR DISCONTINUATION	
_____ / _____		_____ / _____		_____ / _____	
_____ / _____		_____ / _____		_____ / _____	
IVIG ORDERS					
Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____					
Medication			Dose/Frequency		
☐ Asceniv™ 10% ☐ Bivigam® 10% ☐ Gammagard® liquid 10%			☐ Infuse _____ grams intravenously every _____ weeks.		
☐ Gammagard® S/D 5% ☐ Gammagard® S/D 10% ☐ Gammaked™ 10%			☐ Infuse _____ g/kg intravenously every _____ weeks.		
☐ Gamunex®-C 10% ☐ Octagam® 5% ☐ Octagam® 10%			☐ Infuse _____ mg/kg intravenously every _____ weeks.		
☐ Panzyga® 10% ☐ Privigen® 10% ☐ Non-Branded			☐ Other: _____		
Pre-Medication	Route	Dose	Directions	Quantity	Refills
☐ Acetaminophen	☐ PO ☐ IV (ofirmev)	☐ 325mg ☐ 500mg ☐ Other: _____	☐ Pre-Med: _____ ☐ Other: _____	☐ With Each Infusion ☐ Other: _____	#: _____
☐ Diphenhydramine	☐ PO ☐ IV	☐ 25mg ☐ 50mg ☐ Other: _____	☐ Pre-Med: _____ ☐ PRN Reaction: _____	☐ With Each Infusion ☐ Other: _____	#: _____
☐ Other: _____	_____	_____	_____	_____	#: _____
IV Fluids	Route	Dose	Directions	Quantity	Refills

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☐ Normal Saline 0.9% ☐ ½ Normal Saline 0.45% ☐ Dextrose 5% ☐ Other: _____	☐ IV	_____	☐ Before and after infusion ☐ Other: _____	☐ With Each Infusion ☐ Other: _____	#: _____
☐ Other: _____	_____	_____	_____	_____	#: _____
Flush	Route	Dose	Directions	Quantity	Refills
☐ Normal Saline 0.9%	☐ IV	☐ 3 mL ☐ 5mL ☐ 10mL	☐ Before and after infusion ☐ Other: _____	☐ With Each Infusion ☐ Other: _____	#: _____
☐ Heparin 10 units/ml ☐ Heparin 100 units/ml	☐ IV	☐ 3 mL ☐ 5mL ☐ 10mL	☐ After infusion ☐ Other: _____	☐ With Each Infusion ☐ Other: _____	#: _____
Anaphylaxis	Route	Dose	Directions	Quantity	Refills
☐ Diphenhydramine	☐ IV ☐ PO ☐ IM	☐ 25mg ☐ 50mg ☐ Other: _____	☐ Pre-Med: _____ ☐ Other: _____	☐ With Each Infusion ☐ Other: _____	#: _____
☐ Epinephrine	☐ IM ☐ SQ	☐ Adult: 0.3mL (0.3mg) ☐ Peds: 0.15mL (0.15mg)	☐ PRN Anaphylaxis ☐ Repeating Dose: _____	☐ Once ☐ Other: _____	#: _____
☐ Other: _____	_____	_____	_____	_____	#: _____

ANAPHYLACTIC REACTION (AR):

- ☐ EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary
- ☐ EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary
- ☐ Diphenhydramine 50mg (1mL) - Give 50 mg slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary
- ☐ Hydrocortisone 100mg - Give 100 mg IVP -or- IM if no IV access
- ☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of 30 mL/hr

SIGNATURE

X _____
 Prescriber Signature

Date: _____