BioTek reMEDys®

IVIG

Please Fax Completed Form To: 800-783-9146

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

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

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**

IVIG

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☐ Normal Saline 0.9% ☐ ½ Normal Saline 0.45% ☐ Dextrose 5%	☐ 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_____ Date: _____

Prescriber Signature