

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION –AND – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION			
<input type="checkbox"/> D80 Immunodeficiency with predominantly antibody defects	<input type="checkbox"/> D80.1 Nonfamilial hypogammaglobulinemia	<input type="checkbox"/> D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses	<input type="checkbox"/> D83.9 Common variable immunodeficiency (unspecified)
<input type="checkbox"/> G61.0 Guillain-Barré Syndrome	<input type="checkbox"/> G61.81 CIDP	<input type="checkbox"/> G70.00 Myasthenia gravis	<input type="checkbox"/> G70.01 Myasthenia Gravis with (acute) exacerbation
<input type="checkbox"/> M33.2 Polymyositis	<input type="checkbox"/> M33.90 Dermatomyositis	<input type="checkbox"/> M33.10 Other dermatomyositis, organ involvement unspecified	<input type="checkbox"/> Other: _____
Vascular access: <input type="checkbox"/> Peripheral <input type="checkbox"/> Central <input type="checkbox"/> Port Infusion method: <input type="checkbox"/> Gravity <input type="checkbox"/> Pump			
Adverse Reactions with Previous IG treatments? <input type="checkbox"/> No <input type="checkbox"/> Yes Reason/Brand: _____			
Obtain the following labs at prior to start of treatment and at _____ frequency:			
<input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFTs <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: _____			

TRIED AND/OR FAILED MEDICATIONS	LEGNTH OF THERAPY	REASON FOR DISCONTINUATION
_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____
_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____

IVIG ORDERS					
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____					
Medication			Dose/Frequency		
<input type="checkbox"/> Asceniv™ 10%	<input type="checkbox"/> Gammagard® S/D 10%	<input type="checkbox"/> Octagam® 10%	<input type="checkbox"/> Infuse _____ grams intravenously every _____ weeks.		
<input type="checkbox"/> Gammagard® S/D 5%	<input type="checkbox"/> Octagam® 5%	<input type="checkbox"/> Non-Branded	<input type="checkbox"/> Infuse _____ g/kg intravenously every _____ weeks.		
<input type="checkbox"/> Gamunex®-C 10%	<input type="checkbox"/> Privigen® 10%		<input type="checkbox"/> Infuse _____ mg/kg intravenously every _____ weeks.		
<input type="checkbox"/> Panzyga® 10%	<input type="checkbox"/> Gammagard® liquid 10%		<input type="checkbox"/> Other: _____		
Pre-Medication	Route	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO <input type="checkbox"/> IV (ofirmev)	<input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> PRN Reaction: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____
<input type="checkbox"/> Other: _____	_____	_____	_____	_____	#: _____
IV Fluids	Route	Dose	Directions	Quantity	Refills

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<input type="checkbox"/> Normal Saline 0.9%	<input type="checkbox"/> IV	_____	<input type="checkbox"/> Before and after infusion	<input type="checkbox"/> With Each Infusion	#: _____
<input type="checkbox"/> ½ Normal Saline 0.45%			<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Dextrose 5%			_____		
<input type="checkbox"/> Other: _____	_____	_____	_____	_____	#: _____
Flush	Route	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Normal Saline 0.9%	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5mL <input type="checkbox"/> 10mL	<input type="checkbox"/> Before and after infusion <input type="checkbox"/> Other: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____
<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"/> 5mL <input type="checkbox"/> 10mL	<input type="checkbox"/> After infusion <input type="checkbox"/> Other: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____
Anaphylaxis	Route	Dose	Directions	Quantity	Refills
<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"/> Other: _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> IM <input type="checkbox"/> SQ	<input type="checkbox"/> Adult: 0.3mL (0.3mg) <input type="checkbox"/> Peds: 0.15mL (0.15mg)	<input type="checkbox"/> PRN Anaphylaxis <input type="checkbox"/> Repeating Dose: _____	<input type="checkbox"/> Once <input type="checkbox"/> Other: _____	#: _____
<input type="checkbox"/> 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: _____