

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____ ☐ lb ☐ kg
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK of your card

Plan Name: _____ Plan Phone: _____
 ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____
 City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

☐ _____ (ICD-10) _____ (description) ☐ _____ (ICD-10) _____ (description)

Administration Site: ☐ MD Office (disregard remaining questions) ☐ Infusion Suite ☐ Home Health Care
Deliver to: ☐ Patient ☐ Office ☐ Other: _____ Date: _____ Needs by Date: _____

ORDERS

Immunoglobulin: ☐ IVIG ☐ SQIG **Per Market Availability** First Dose: ☐ Yes ☐ No

Medication (10% assumed unless otherwise indicated)	Route	Dose/Strength/ Directions	Dosing Weight	Refills
☐ Octagam ☐ Panzyga ☐ Gammaked ☐ Gammagard ☐ Gammagard S/D ☐ Bivigam ☐ Carimune-NF ☐ Cuvitru ☐ Flebogamma	☐ Gamastan S/D ☐ Gammaplex ☐ Gamunex-C ☐ Hizentra ☐ HyperRHO S/D ☐ HyQvia Privigen ☐ Other: _____	☐ SC ☐ IV ☐ Initial dose: infuse _____ grams or _____ grams per kg divided over _____ days, discard remaining. ☐ Maintenance dose: infuse _____ grams or _____ grams per kg every _____ weeks, divided over _____ days, discard remaining.	☐ Actual ☐ Ideal ☐ Adjusted ☐ Other _____	

Pre-Medications as needed 30 minutes before start of IG:

Medication	Route	Dose/Strength
☐ Famotidine	☐ PO ☐ IV	20 - 40 mg
☐ Ondansetron	☐ PO ☐ IVP	4 - 8 mg
☐ Solu-Medrol	☐ IM ☐ IVP	125 mg
☐ Toradol	☐ IVP	30 mg
☐ Other: _____		

Medications to be used as needed: (please strike through if not required)
 Diphenhydramine 25 mg by mouth every 4-6 hours as needed for mild infusion reactions, may increase to 50 mg for moderate to severe; maximum of 4 doses per day (contraindicated in patients with myasthenia gravis).
 Lidocaine 4% applied topically to insertion site prior to needle insertion as needed to prevent site pain.
 Acetaminophen 500 mg by mouth every 4-6 hours as needed for fever, headache or chills; maximum of 4 doses per day.

Adverse reaction medications: (keep on hand at all times)
 Epinephrine 0.3 mg auto-injector 2-pk for patients weighing greater than or equal to 30 kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose.
 Epinephrine 0.15 mg auto-injector 2-pk for patients weighing less than 30 kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose.
 Diphenhydramine 25 mg by mouth for mild allergic reactions and 50 mg for moderate to severe.

Hydration	Nursing and other orders:
Medication: ☐ 0.9% Normal Saline _____ ml infused over _____ minutes ☐ D5W _____ ml infused over _____ minutes Timing: ☐ Pre-IG infusion _____ minutes before ☐ Post-IG infusion ☐ To be completed during the IVIG infusion ☐ Other _____	Administer IVIG or teach SCIG self-administration, via pump. Ambulatory pump if required for infusion. Maintain PICC line, Port-a-Cath, or Midline. Initiate access device: Peripheral IV for IVIG via peripheral line or for SQIG via SQ pump. Labs to be ordered and monitored by physician. Skilled nursing visit weekly or as needed to establish venous access, administer medication and assess general status and response to therapy. Administer medications and utilize pump if needed.

Flushing orders: 0.9% Normal Saline 3 mL intravenous or 10mL intravenous before and after infusion, or as needed for line patency.
 Heparin 10 units per mL 3 mL intravenous as needed for final flush.
 Heparin 100 units per mL 5 mL intravenous as needed for final flush.

Supplies: (please strike through if not required) Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

Labs to be ordered and monitored by physician. ☐ Other _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution Permitted ☐ Dispense as Written

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____