

Date Required: _____ Ship To: Home Office Other: _____

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Alternate Phone: _____
 Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Fax: _____
 DEA #: _____ NPI #: _____
 Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
 Secondary Insurance: _____ ID: _____ Group: _____
 Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

D69.0 Allergic Purpura
 D69.3 Immune Thrombocytopenic Purpura (ITP)
 E83.110 Neonatal Hemochromatosis
 O36.0110 Rh Sensitization or Severe Isoimmunization
 P61.0 Transient Neonatal Thrombocytopenia (NAIT)
 Other: _____

MEDICAL HISTORY

Has patient previously received IVIG? Yes No
 Patient Weight: _____ kg lbs Height: _____ cm in
 Allergies: _____
 Line Access: Peripheral PICC Port
 Delivery Method: Infusion Pump Other: _____
 Therapy Start Date: _____ Therapy End Date: _____
 Nursing Coordination:
 Pharmacy to coordinate home health nursing visit as necessary: Yes No
 Home health nursing coordination not necessary. Reason:
 MD office to administer to patient
 Home health nursing already coordinated

FOR NAIT

Has HPA-1a testing been completed? Yes No
 Results Confirm NAIT: Yes No

FOR ITP

Platelet Count: _____ Date: _____

Lab Orders: _____
 Concurrent Medications: _____
 Current Gestational Age: _____
 EDC: _____
 Gravida: _____
 Para: _____

Renal insufficiency
 Thromboembolic event
 CHF
 Diabetes
 HTN
 Other: _____

PRESCRIPTION INFORMATION

Loading Dose: IVIG _____ gm or _____ gm/kg once daily for _____ day(s)
Maintenance: IVIG _____ gm or _____ gm/kg once daily for _____ day(s)
 Repeat course every _____ week(s) x _____ course(s)
 Refill x _____ (length of time)

OK to round to the nearest vial size
 +/- 4 days to allow scheduling flexibility
 Multiple doses will be administered on consecutive days unless ordered otherwise.
 non-consecutive days only

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol
 NaCl 0.9% 5ml Heparin 10 units/ml 250ml 0.9% NaCl for hydration
 NaCl 0.9% 10ml Heparin 100 units/ml Other: _____

Pre-Medications & Other Medications
 Infusion supplies as per protocol Acetaminophen _____ mg PO prior to infusion
 Anaphylaxis Kit orders as per protocol Diphenhydramine _____ mg PO

Prescriber Signature: _____ **Date:** _____

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