

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:**

For immune deficiency:  
 Detailed infection history, baseline IgG levels (including subclasses),  
 immune response to vaccinations (including report)  
 Other: \_\_\_\_\_

Patient demographics, including insurance information.  
 Labs – Antibody testing results, most recent BUN/SCr and IgA level  
 H&P  
 Please attach original prescription orders

**DIAGNOSIS**

**Immunological:**

D81.9 Combined Immunodeficiency, Unspecified  
 D83.9 Common Variable Immunodeficiency (CVID)  
 D80.0 Hereditary Hypogammaglobulinemia  
 D84.9 Immunodeficiency, Unspecified  
 D80.5 Immunodeficiency with Hyper IgM  
 D80.1 Nonfamilial Hypogammaglobulinemia  
 D80.2 Selective IgA Immunodeficiency  
 D80.3 Selective IgG Immunodeficiency  
 D80.4 Selective IgM Immunodeficiency  
 D81.0 Severe Combined Immunodeficiency (SCID)  
 D82.0 Wiskott-Aldrich Syndrome  
 Other: \_\_\_\_\_

**PATIENT EVALUATION**

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

**PRESCRIPTION INFORMATION**

**Rx Intravenous Route:**  
 IVIG \_\_\_\_\_ grams daily for \_\_\_\_\_ day(s)  
 Repeat course every \_\_\_\_\_ week(s) for a total of \_\_\_\_\_ course(s).

**Rx Subcutaneous Route:**  
 IG \_\_\_\_\_ grams each month given as \_\_\_\_\_ doses or IG \_\_\_\_\_ grams \_\_\_\_\_ times per month.  
 Administer SCIG using \_\_\_\_\_ sites at a time. Repeat \_\_\_\_\_ week(s). Refill x 1yr.

Brand: \_\_\_\_\_  Pharmacy to select brand

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:** \_\_\_\_\_