

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

Neurological:

G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
 M33.10 Dermatomyositis
 G61.0 Guillian-Barré Syndrome
 G70.80 Lambert-Eaton Syndrome
 G62.89 Multifocal Motor Neuropathy (MMN)
 G35 Multiple Sclerosis (Relapsing/Remitting)
 G70.01 Myasthenia Gravis w/Acute Exacerbation
 G62.9 Polyneuropathy, Unspecified
 M33.22 Polymyositis
 G25.82 Stiff-Person 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

Patient demographics, including insurance information.
 Labs – Antibody testing results, most recent BUN/SCr and IgA level
 H&P
 Medications/Therapies tried and failed
 Baseline assessment, including detailed patient symptoms
 Please attach original prescription orders

As Appropriate:

Nerve Conduction Study results, including velocities
 Biopsy results
 Electromyography (EMG) results
 CSF studies
 Other: _____

PRESCRIPTION INFORMATION

Immune Globulin Prescription:
Loading Dose: IVIG _____ gm/kg given over _____ day(s) OR _____ gm daily for _____ day(s)
Maintenance: IVIG _____ gm/kg given over _____ day(s) OR _____ gm daily for _____ day(s)
 Repeat course every _____ week(s) x _____ course(s)
 Refill x _____ (length of time)
Subcutaneous Prescription:
 IG _____ gm monthly OR _____ gm every _____ weeks.
 Administer SCIG using _____ sites at a time. Repeat _____ week(s). Refill x 1yr.

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:** _____