

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

G04.81 Other Encephalitis and Encephalomyelitis
 M33.90 Dermatomyositis
 D69.3 Idiopathic Thrombocytopenia Purpura
 M30.3 Kawasaki Disease
 L12.8 Pemphigoid, Unspecified
 L10.9 Pemphigus, Unspecified
 M33.20 Polymyositis
 Other: _____

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

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

Immune Globulin Prescription:
Loading Dose: IVIG _____ gm per kg given over _____ day(s) OR _____ gm daily for _____ day(s)
Maintenance: IVIG _____ gm per kg given over _____ day(s) OR _____ gm 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 per ml 250ml 0.9% NaCl for hydration
 NaCl 0.9% 10ml Heparin 100 units per 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:** _____