IVIG

New Prescription/Referral
Prescription Refill

 # Of Refills:

Rx: Patient Name: | Patient Weight: kg | DOB:

BRAND: OK to use biosimilar

Gamunex (10%) Privigen (10%) Octagam (10%) Gammaplex (10%)
Gammagard (10%) Bivigam (10%) Gammaked(10%) Flebogamma DIF (10%)
Asceniv (10%) Panzyga (10%) Other orders:____________________________

DOSAGE:

_________g/day IV _________g/kg IV Over______#of days _________#of months

FREQUENCY:

One-Time only every______weeks (Optional: Start Date_________________)

OTHER ORDERS:____

____

Pre-Medication:

Solumedrol 125mg IVP Tylenol ______ mg PO Benadryl ______ mg PO
Solu-Cortef 100mg IVP 650 mg 975 mg 1000mg 25 mg 50 mg IV PO
Others: ______________________________

ANA Kit Protocol:
OK to use

Dx:

Chronic Inflammatory Demyelinating Polyneuropathy (G61. 81)
Idiopathic Thrombocytopenic Purpura (D69. 3)
Multifocal Motor Neuropathy (G61. 82)
Myasthenia Gravis (G70. 00)
Hypogammaglobulinemia(D80. 1)
Primary Immunodeficiency (D83.)

Other:____

ICD-10: ____

Physician Signature NPI #: DATE:(Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name: | Clinic:

Phone: Fax: Email: Other:

Office Mailing Address:

Please include the following

Patient demographics Insurance attached Diagnosis(supporting) History & Physical
Lab Results Clinical progress notes Medication list Other Test Results

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.