*Patient Insurance & ID (front and back) are needed

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 ☐ IV ☐ 50 mg ☐ 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.