Immunoglobulin Form





Fax completed form to:

Tax completed to	THI to:					
		PATIEN'	T INFORMATION			
Patient Name:		Date of Birth:			Referral Date:	
Address:				City/State/Zi	p:	
Home Phone:		Cell Phone:			Work Phone:	
Secondary Contact:		Height:	Weight:		Male Female	
Patient Diagnosis & ICD-10:						
Allergies:						
PROVIDER INFORMATION						
Physician Name:		Lic.#:		DEA #:		
Practice Name:			NPI#:			
Address:			City/State/Zip:			
Office Contact:		Phone:			Fax:	
Supervisory Physician (if appl	icable):					
PLEASE ATTACH						
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with dates) Letter of medical necessity if drug dosing or indication is outside of FDA guidelines						
Additional information required for neurology diagnosis only Recent BUN & Creatinine results Diagnostic testing (one or all) to match diagnosis: Electromyography (EMG) Nerve Biopsy Muscle Biopsy Nerve Conduction Study			Additional information required for immunology diagnosis only IG Serum Levels: IgG, IgA, and IgM Subclass Levels: Ig1, Ig2, Ig3, Ig4 Recent BUN & Creatinine results Immunization challenge test results and titers values Supporting documentation of chronic infection history, hospitalizations & previous treatment			
		NURSIN	G & LAB ORDERS	3		
Nunca Ondones Nunca to prov	ido accossment teaching lab draws m				unagement ner physician erders	
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.						
Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mLOR 10units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line						
Lab Orders: Lab Date & Frequency:						
PRESCRIPTION ORDERS						
Anaphylaxis Kit: Epinephrine 0.3mg IM as needed Solu-cortef 250mg-500mg IV infusion as needed Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply) Diphenhydramine mg IV infusion as needed NS Hydration 500 ml IV infusion over 30 minutes as needed Other						
Pre-Medications: Acetaminophenmg POminutes prior to infusion Solu-Medrolmg IVminutes prior to infusion (Check all that apply) Heparin 5,000 units SubQ pre and post IG infusion Diphenhydraminemg POOR IV infusionminutes prior to infusion Other Pre-Hydration NS Hydration 250ml-500 ml IV infusion over 30 minutes as needed						
Supply Orders: All supplies	for vascular access line care, drug admir	istration kit(s), pump, and	IV pole will be provided as neo	essary		
PRODUCT		PRESCRI	PTION INFORMA	TION		REFILLS
Is this a first dose? Yes	No If No, when was last dose give	n?	_When is patient due for next o	lose?		
IMMUNOGLOBULINS	mg/k	n OR SC infusion g divided overdays g for one time dose veryweeks		RPh Re	commended Brand	
OTHER						
By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.						
Prescriber's Signature Dispense as Written	Print Name	Date	Prescriber's Signa Substitution Pern		Print Name	Date

No MD signature required on this form for infusion therapy. The pharmacist or NP will be sending a fax with prescription order details that must be signed by the physician before this drug can be dispensed.





