

# Immunoglobulin Form



Fax completed form to: \_\_\_\_\_

PATIENT INFORMATION			
Patient Name:		Date of Birth:	Referral Date:
Address:		City/State/Zip:	
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 applicable):			
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	
<b>Additional information required for neurology diagnosis only</b> Recent BUN & Creatinine results Diagnostic testing (one or all) to match diagnosis: Electromyography (EMG) Nerve Biopsy Muscle Biopsy Nerve Conduction Study		<b>Additional information required for immunology diagnosis only</b> 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	
NURSING & LAB ORDERS			
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.			
<b>Flush Orders:</b> NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mL ---OR--- 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line			
<b>Lab Orders:</b> <span style="float: right;"><b>Lab Date &amp; Frequency:</b></span>			
PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b>			
(Check all that apply)	Epinephrine 0.3mg IM as needed	Solu-cortef 250mg-500mg IV infusion as needed	Solu-Medrol 60mg - 125mg IV infusion as needed
	Diphenhydramine _____mg IV infusion as needed	NS Hydration 500 ml IV infusion over 30 minutes as needed	Other
<b>Pre-Medications:</b>			
(Check all that apply)	Acetaminophen _____mg PO _____minutes prior to infusion	Solu-Medrol _____mg IV _____minutes prior to infusion	
	Heparin 5,000 units SubQ pre and post IG infusion	Diphenhydramine _____mg PO ---OR--- IV infusion _____minutes prior to infusion	Other
	Pre-Hydration	NS Hydration 250ml-500 ml IV infusion over 30 minutes as needed	
<b>Supply Orders:</b> All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary			
PRODUCT	PRESCRIPTION INFORMATION		REFILLS
Is this a first dose?    Yes    No    If No, when was last dose given? _____ When is patient due for next dose? _____			
IMMUNOGLOBULINS	Administration Route:    IV infusion ---OR---    SC infusion Dosing/Frequency:    _____mg/kg divided over _____days every _____weeks _____mg/kg for one time dose _____mg every _____weeks		RPh Recommended Brand
OTHER			
<b>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.</b>			

**Prescriber's Signature**                      **Print Name**                      **Date**  
Dispense as Written

**Prescriber's Signature**                      **Print Name**                      **Date**  
Substitution Permitted

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.



ACHC ACCREDITED

