

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	
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	
NURSING & LAB ORDERS			
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/mL ---OR--- 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line			
Lab Orders: Lab Date & Frequency:			
PRESCRIPTION ORDERS			
Anaphylaxis Kit: (Check all that apply)	Epinephrine 0.3mg IM as needed Diphenhydramine _____mg IV infusion as needed	Solu-cortef 250mg-500mg IV infusion as needed NS Hydration 500 ml IV infusion over 30 minutes as needed	Solu-Medrol 60mg - 125mg IV infusion as needed Other _____
Pre-Medications: (Check all that apply)	Acetaminophen _____mg PO _____minutes prior to infusion Heparin 5,000 units SubQ pre and post IG infusion Pre-Hydration NS Hydration 250ml-500 ml IV infusion over 30 minutes as needed	Solu-Medrol _____mg IV _____minutes prior to infusion Diphenhydramine _____mg PO ---OR--- IV infusion _____minutes prior to infusion	Other _____
Supply Orders: 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			_____

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 _____ **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.