

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:	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:	Acetaminophen _____mg PO _____minutes prior to infusion	Solu-Medrol _____mg IV _____minutes prior to infusion	
(Check all that apply)	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		

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
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	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 <div style="text-align: right; margin-top: 10px;">RPh Recommended Brand</div>	_____
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 Signature Substitution Permitted	Print Name	Date
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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.