Immunoglobulin Form





Fax completed form to:

			NT INFORMATIO	N				
Patient Name:					Poforral Data:			
Patient Name: Address:		Date of Birth:			Referral Date:			
Home Phone:		Cell Phone:		City/State/Zip:	Work Phone:			
Secondary Contact:		Height:	Weight:		Male Female			
Patient Diagnosis & ICD-10:		Ticigiit.						
Allergies:								
Allergies.		DROVU						
			DER INFORMATI					
Physician Name:		Lic.#:		DEA #:				
Practice Name:				NPI#:				
Address:				City/State/Zip:				
Office Contact:		Phone:			Fax:			
Supervisory Physician (if app	licable):							
		PI	LEASE ATTACH					
	front/back copy of all insurance cards nistory & physical, lab & pertinent pro				edications tried and failed (wi g or indication is outside of FE			
Recent BUN & Creatinine results IG Se Diagnostic testing (one or all) to match diagnosis: Subor Electromyography (EMG) Recent				onal information required for immunology diagnosis only Gerum Levels: IgG, IgA, and IgM Aclass Levels: Ig1, Ig2, Ig3, Ig4 ent BUN & Creatinine results				
Nerve Biopsy Immunization challenge test results and titers values Muscle Biopsy Supporting documentation of chronic infection history, hospitalizations & prevent Nerve Conduction Study Nerve Conduction Study						s & previous treatr	nent	
		NURSI	ING & LAB ORDE	RS				
Nurse Orders: Nurse to prov	vide assessment, teaching, lab draws,	medication administration	n and vascular access device ins	ertion and/or man	agement per physician orders			
	-							
Flush Orders: NaCl 0.9% - 5	-10mL flush pre and post infusion an	d as needed Heparin -	10units/mL 0R 100	units/mL - 3-5mL f	lush after post-infusion NS flu	ish if indicated to r	naintain line	
Lab Orders:			Lab Date & Frequency	<i>I</i> :				
		PRESC	CRIPTION ORDER	RS				
Anaphylaxis Kit: (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							
Pre-Medications:	Acetaminophen mg P0 minutes prior to infusion Solu-Medrol mg IVminutes prior to infusion							
(Check all that apply) Heparin 5,000 units SubQ pre and post IG infusion Diphenhydramine mg P0 OR IV infusionminutes prior to infusion Other Pre-Hydration NS Hydration 250ml-500 ml IV infusion over 30 minutes as needed NS Hydration 250ml-500 ml IV infusion NS Hydration 250ml-500 ml IV infusion								
Supply Orders: All supplies	for vascular access line care, drug adr	ninistration kit(s), pump, a	and IV pole will be provided as r	necessary				
PRODUCT		PRESCI	RIPTION INFORM	IATION			REFILLS	
Is this a first dose? Yes	No If No, when was last dose gi	ven?	When is patient due for ne	xt dose?				
IMMUNOGLOBULINS	Administration Route: IV infusion OR SC infusion Dosing/Frequency: mg/kg divided overdays everyweeks mg/kg for one time dose mg everyweeks RPh Recommended Brand							
OTHER								
By signing this form and uti	lizing our services, you are authoriz	ing Amerita, Inc. to serve	e as your prior authorization a	lesignated agent i	n dealing with medical and	prescription insu	rance companies.	
Prescriber's Signature Dispense as Written	Print Name	Date	Prescriber's Sig Substitution Pe		Print Name	Date	•	



