IVIG

☐ New Prescription/Referral
☐ Prescription Refill

# of Refills:

Rx:

Patient Name:

DOB:

Brand:

☐ Gamunex (10%) ☐ Privigen (10%) ☐ Octagram (10%) ☐ Gammaplex (10%)
☐ Gammagard (10%) ☐ Flebogamma DIF (10%) ☐ Gammaked (10%) ☐ Carimune (____%)

Dosage:

☐ _____ gm/day ☐ _____ mg/kg _____ # of days _____ # of months

Frequency:

☐ One-Time only ☐ every _____ weeks (Optional: Start Date _____)

Other Orders:

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Others:

☐ Tylenol _____mg PO
☐ 650mg ☐ 975mg

☐ Benadryl _____mg
☐ 25mg ☐ IV
☐ 50mg ☐ PO

ANA Kit Protocol:

☐ OK to use

Dx:

☐ Chronic Inflammatory Demyelinating Polyneuropathy (G61. 81)
☐ Idiopathic Thrombocytopenic Purpura (D69. 3)
☐ Multifocal Motor Neuropathy (G61. 82)
☐ Others:

☐ Myasthenia Gravis (G70. 00)
☐ Hypogammaglobulinemia(D80. 1)
☐ Primary Immunodeficiency (D83.)

Physician Signature

N P I #:

Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone:

Fax:

Email:

Other:

Office Mailing Address:

Please include the following

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis (supporting) ☐ History and Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication List ☐ Other Test Results