MAIN POINT OF CONTACT

Name: _____

Phone: _____

ALLIED PHARMACY

SUBCUTANEOUS IMMUNOGLOBULIN

Ph: 832-365-3420 Fax: 855-595-2955

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____

Weight:_____lbs. Emergency Contact:_____

Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:			Secondary Insurance:	
ID#:	RxBin:		ID#:	RxBin:
RxGroup:	Pcn:		RxGroup:	Pcn:

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ CUTAQUIG	☐ 16.5% (1G VIAL) ☐ 16.5% (2G VIAL) ☐ 16.5% (4G VIAL) ☐ 16.5% (8G VIAL)	☐ Inject _____mL SQ once weekly ☐ Inject _____mL SQ once every _____weeks	_____VIAL(S)	
☐ CUVITRU	☐ 20% (1G VIAL) ☐ 20% (2G VIAL) ☐ 20% (4G VIAL) ☐ 20% (8G VIAL) ☐ 20% (10G VIAL)	☐ Inject ____mL SQ once weekly ☐ Inject ____mL SQ once every ____weeks	_____VIAL(S)	
☐ HIZENTRA	☐ 20% (1G SYRINGE) ☐ 20% (2G SYRINGE) ☐ 20% (4G SYRINGE) ☐ 20% (10G SYRINGE)	☐ Inject ____mL SQ once weekly ☐ Inject ____mL SQ once every ____weeks	_____SYRINGE(S)	

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address: City: State: Zip Code:

Phone: Fax:

***Prescriber Signature:** **Date:**

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone numbers set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

Please fax completed form to 1 (855) 595-2955

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RxGroup:	Pcn:		RxGroup:	Pcn:

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Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ HYQVIA	☐ 10% (2.5G VIAL) ☐ 10% (5G VIAL) ☐ 10% (10G VIAL) ☐ 10% (20G VIAL) ☐ 10% (30G VIAL)	☐ Inject ____mL SQ once weekly ☐ Inject ____mL SQ once every ____weeks	_____VIAL(S)	
☐ XEMBIFY	☐ 20% (1G VIAL) ☐ 20% (2G VIAL) ☐ 20% (4G VIAL) ☐ 20% (10G VIAL)	☐ Inject ____mL SQ once weekly ☐ Inject ____mL SQ once every ____weeks	_____VIAL(S)	

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Phone:		Fax:	

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