

Patient information	Prescriber + Shipping Information
Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ 1° Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate Phone: _____ Caregiver name: _____ Relation: _____ Local Pharmacy: _____ Phone: _____	Prescriber Name: _____ NPI #: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address: _____ If shipping to prescriber: <input type="checkbox"/> 1st Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Insurance Information (Please fax a copy of front and back of the insurance cards)			
1° Insurance Plan: _____	Plan ID #: _____	Policy Holder: _____	Relation: _____
2° Insurance Plan: _____	Plan ID #: _____	Policy Holder: _____	Relation: _____

Clinical Information (Please fax all pertinent clinical and lab information)	
ICD-10/Diagnosis Code: _____ Date of Diagnosis: _____ IgA deficiency: <input type="checkbox"/> Yes <input type="checkbox"/> No IgA level _____ mg/dL Date: _____ IgG trough: _____ mg/dL Date: _____ Diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No Comorbidities: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____	Access: <input type="checkbox"/> Peripheral Butterfly <input type="checkbox"/> PICC <input type="checkbox"/> Implant Port <input type="checkbox"/> Broviac®/Hickman® Has patient received immune globulin previously? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, product information: _____ Date of last infusion: _____ Date of next infusion: _____

Prescription	
Immune Globulin Products	<input type="checkbox"/> Bivigam® 10% <input type="checkbox"/> Carimune® NF <input type="checkbox"/> Flebogamma® 5% <input type="checkbox"/> Flebogamma® 10% <input type="checkbox"/> GammaKed® 10% <input type="checkbox"/> Gammagard® Liquid10% <input type="checkbox"/> Gammaplex® 5% <input type="checkbox"/> Gammagard® S/D <input type="checkbox"/> Gamunex-C® 10% <input type="checkbox"/> Octagam® 5% <input type="checkbox"/> Octagam® 10% <input type="checkbox"/> Privigen® 10% <input type="checkbox"/> IVIG (Pharmacy to determine)
Therapy Regimen	Dose: _____ g/kg Total dose: _____ grams Daily for _____ days every _____ weeks # Doses: _____ Refills: _____ Administration Rate: <input type="checkbox"/> Per manufacture guidelines, as tolerated <input type="checkbox"/> _____
Pre-Medications and Pre-Protocol	<input type="checkbox"/> Diphenhydramine _____ mg 30 min before infusion <input type="checkbox"/> PO <input type="checkbox"/> IVP <input type="checkbox"/> Acetaminophen _____ mg 30 min before infusion PO <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____
Flushing Protocol	<input type="checkbox"/> Sodium Chloride 0.9% 5-10 mL pre and post medications <input type="checkbox"/> Heparin _____ Units/mL _____ mL as needed <input type="checkbox"/> Hydration Infuse _____ mL _____ solution <input type="checkbox"/> Prior to <input type="checkbox"/> During <input type="checkbox"/> Following <input type="checkbox"/> Solu-Cortef® _____ mg slow IVP <input type="checkbox"/> Solu-Medrol® _____ mg slow IVP <input type="checkbox"/> Pre <input type="checkbox"/> Halfway <input type="checkbox"/> Upon completion
Anaphylaxis Orders and Medications	Orders: 1. Stop infusion 2. Call 911 and prescribing physician 3. Administer medications below as per protocol <input type="checkbox"/> Diphenhydramine Administer 25-50 mg slow IV/IM Dispense: 1 x 50 mg vial <input type="checkbox"/> Epinephrine <input type="checkbox"/> Administer 0.3 mg (1:1000) Sub-Q (≥ 30 Kg) <input type="checkbox"/> Administer 0.15 mg (1:2000) Sub-Q (< 30 Kg) Dispense: 1 vial <input type="checkbox"/> Sodium Chloride 0.9% Use as directed per the protocol Dispense: 1 x 500 mL Bag
Ancillary Supplies	<input type="checkbox"/> As needed for proper administration and disposal of medication
Skilled Nursing Visits	<input type="checkbox"/> As needed for IV access, administration and proper clinical monitoring

Administration procedures to be followed per pharmacy protocol.

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize AmeriPharma Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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