P: 832-813-8932

F: 888-883-9901

IMMUNOGLOBULIN RX FORM

PATIENT INFORMATION

PATIENT NAME: _____ **DOB** _____/_____/_____ **PHONE:** (_____) - _____ - _____

PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE INFORMATION AND DEMOGRAPHICS

MEDICATION

IVIG BRAND IV
- ☐ GAMMAGARD LIQUID
- ☐ GAMUNEX - C
- ☐ BIVIGAM
- ☐ GAMMAKED 10%
- ☐ HYQVIA
- ☐ FLEBOGAMMA 5%
- ☐ FLEBOGAMMA 10%
- ☐ PRIVIGEN 10%
- ☐ GAMMAGARD S/D
- ☐ GAMMAPLEX 5%
- ☐ OTHER: _____

DOSAGE: _____GM/KG DIVIDED OVER _____ DAY(S)
DOSAGE: _____MG/KG DIVIDED OVER _____ DAY(S)

FREQUENCY: EVERY _____ WEEKS FOR ONE YEAR
FREQUENCY: EVERY _____ WEEKS FOR _____

PRE-MEDICATIONS

BENADRYL IV _____ MG
REGLAN IV _____ MG
SOLUMEDROL IV _____ MG
ZOFRAN IV _____ MG
OTHER IV_____ MG

BENADRYL PO _____ MG
TYLENOL PO _____ MG
ZYRTEC PO _____ MG
ZOFRAN PO _____ MG
ZANTAC PO _____ MG
OTHER PO_____ MG

IF APPLICABLE, DATE OF LAST INFUSION: _____

MEDICAL INFORMATION

WEIGHT: _____**LBS** **HEIGHT:** _____ **IN**

ALLERGIES: _____ ☐ **N.K.D.A**

DATE OF BMP: _____

DATE OF Ig _____ **SERUM:** _____

DATE OF CBC: _____

PREVIOUSLY FAILED MEDICATIONS/DOSE:

#1_____ **DATE RANGE:** _____
#2_____ **DATE RANGE:** _____
#3_____ **DATE RANGE:** _____

PATIENT WILL BE DISCONTINUING: _____

PLEASE ATTACH ALL MEDICAL RECORDS, INCLUDING LAB WORK, CLINICAL NOTES, HOSPITALIZATION RECORDS, OR SURGICAL PROCEDURES

DIAGNOSIS

DIAGNOSIS: _____

ICD-10: _____

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing our company (based on preferred location) and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

PHYSICIAN NAME (PRINTED): _____ **NPI:** _____

PHONE: _____ **FAX:** _____ **CONTACT PERSON:** _____

PHYSICIAN NAME (SIGNED): _____ **DATE:** _____