



P: 832-813-8932

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# 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  FLEBOGAMMA 5%  
 GAMUNEX - C  FLEBOGAMMA 10%  
 BIVIGAM  PRIVIGEN 10%  
 GAMMAKED 10%  GAMMAGARD S/D  
 HYQVIA  GAMMAPLEX 5%  
 OTHER: \_\_\_\_\_

DOSAGE: \_\_\_\_\_ GM/KG DIVIDED OVER \_\_\_\_\_ DAY(S)  
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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: \_\_\_\_\_

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