**Patient Information**

Please submit front and back copies of all medical & prescription insurance cards.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⬜ Male ⬜ Female Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt/Suite: \_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alt Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*\*May we leave a message on either line? ⬜ YES ⬜ NO May we text you? ⬜ YES ⬜ NO Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinical Information**

Please submit clinic notes, medical history, labs, test results, and medication list.

Allergies: ⬜ NKDA ⬜ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Access Type: ⬜ Peripheral ⬜ Implanted Port ⬜ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Ig Therapy? ⬜ No ⬜ Yes, and Product Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last treat: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ht: \_\_\_\_\_\_\_\_\_\_\_\_ ⬜ IN ⬜ CM Wt: \_\_\_\_\_\_\_\_\_\_\_\_ ⬜ LB ⬜ KG Do you want Ig dose adjusted for weight > 100 kg? ⬜ No ⬜ Yes

**Prescription Order**

Administered per manufacturer guidelines. Per state law, prescriptions will be dispensed as generic unless otherwise noted.

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| IVIG: ⬜ Pharmacist to select appropriate product per insurance formulary, or ⬜ Brand: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_⬜ LOADING DOSE: Administer over \_\_\_\_\_\_\_\_\_ days. ⬜ Fixed-dose: \_\_\_\_\_\_\_\_\_\_\_\_ TOTAL grams, or ⬜ Weight-based: \_\_\_\_\_\_\_\_\_ g/kg⬜ MAINTENANCE DOSE: Administer over \_\_\_\_\_\_\_ days. ⬜ Fixed-dose: \_\_\_\_\_\_\_\_\_\_\_\_ TOTAL grams, or ⬜ Weight-based: \_\_\_\_\_\_\_\_\_ g/kgFrequency: Repeat cycle every \_\_\_\_\_\_\_\_\_\_\_ ⬜ days ⬜ weeks. \* \* May adjust infusion schedule +/- 3 days if nursing need arises \* \*Other Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ANCILLARY MEDICATIONS: ⬜ With every infusion ⬜ PRN upon patient request.⬜ Acetaminophen \_\_\_\_\_\_\_\_\_\_\_\_ mg PO. ⬜ Give 30 to 60 minutes before infusion. ⬜ May repeat every \_\_\_\_\_\_\_\_ hours PRN.⬜ Diphenhydramine \_\_\_\_\_\_\_\_\_\_\_\_ mg ⬜ PO ⬜ IV. ⬜ Give 30 to 60 minutes before infusion. ⬜ May repeat every \_\_\_\_\_\_\_\_ hours PRN.⬜ Hydration: Infuse \_\_\_\_\_\_\_\_\_\_\_\_ mL of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ solution ⬜ before ⬜ after infusion.⬜ SoluMedrol® ⬜ SoluCortef® Give \_\_\_\_\_\_\_\_\_\_\_ mg prior to infusion via ⬜ IV push ⬜ diluted in \_\_\_\_\_\_\_\_\_\_ mL of NS over 30 minutes.⬜ Emla® cream (30 grams). Apply topically 30 to 60 minutes prior to access.⬜ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| FLUSHING PROTOCOL: ☑ Sodium chloride 0.9%, 5-10 mL before/after medication, and/or PRN to maintain patency.⬜ Heparin \_\_\_\_\_\_\_\_\_\_ units/mL, \_\_\_\_\_\_\_\_\_\_\_ mL as final flush and/or PRN to maintain patency |
| ANAPHYLAXIS PROTOCOL: 1) Stop infusion. Call 911. 2) Administer medications below per protocol. |
| Epinephrine (vial or autoinjector): Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes x 1.⬜ 0.3 mg (Wt > 30 kg) ⬜ 0.15 mg (Wt 15-30 kg) ⬜ 0.1 mg (Wt 7.5-15 kg) | Diphenhydramine (50mg/mL vial) via IM or slow IV push⬜ 50 mg (Wt > 30 kg) ⬜ 25 mg (Wt 15-30 kg) ⬜ 12.5mg (Wt 7.5-15kg)☑ Sodium Chloride 0.9%, 500 mL IV as directed |
| NURSING / LABS / SUPPLIES:☑ Nursing visits with each infusion to establish venous access, administer medication, assess and monitor patient, provide education, and complete lab draws.☑ Infusion supplies and infusion pump PRN for the administration and disposal of medication.⬜ [Dx code: Z79.899] Labs to be drawn by RN prior to infusion every \_\_\_\_\_\_\_\_\_ ⬜ weeks ⬜ month(s), as follows: ⬜ CMP ⬜ CBC w/ diff ⬜ ESR ⬜ CK ⬜ IgG, total ⬜ IgG, subclasses 1-4 ⬜ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dispense (all above): ⬜ up to 1-month supply + refills x 1 year ⬜ up to 3-month supply + refills x 1 year ⬜ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Prescriber Information**

Prescriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt/Suite: \_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_

Office Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescriber’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize IV Solutions Rx and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions Rx. CONFIDENTIALITY NOTICE: The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by replying by email at info@ivsolutionsrx.com and then destroying all copies of the original message.