

**Patient Information**

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

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

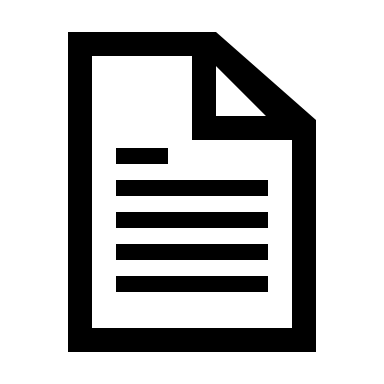
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt/Suite: \_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_

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**

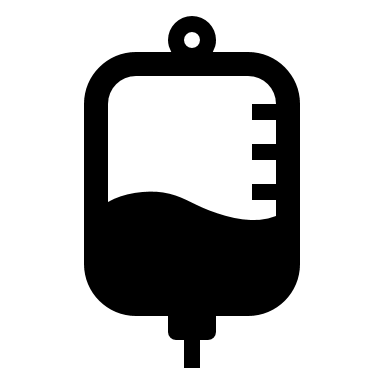
Please submit clinic notes, medical history, labs, test results, and medication list.

Allergies: ⬜ NKDA ⬜ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Ht: \_\_\_\_\_\_\_\_\_\_\_\_ ⬜ IN ⬜ CM Wt: \_\_\_\_\_\_\_\_\_\_\_\_ ⬜ LB ⬜ KG



**Prescription Order**

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

**Prescriber Information**



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| SCIG: ⬜ Pharmacist to select appropriate product per insurance formulary, or ⬜ Brand: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOSE: ⬜ Fixed-dose: \_\_\_\_\_\_\_\_\_\_\_\_ TOTAL grams, or  ⬜ Weight-based: \_\_\_\_\_\_\_\_\_ g/kg. ⬜ If tolerance issues arise, may divide dose and infuse over 2 administration days.  Repeat cycle every \_\_\_\_\_\_\_\_\_\_\_ ⬜ days ⬜ weeks. Pharmacist to determine infusion rate and # of admin sites unless otherwise instructed.  ⬜ Other Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ANCILLARY MEDICATIONS:  ⬜ Acetaminophen \_\_\_\_\_\_\_\_\_\_\_\_ mg PO ⬜ 30 to 60 minutes before infusion PRN. ⬜ May repeat every \_\_\_\_\_\_\_\_ hours PRN.  ⬜ Diphenhydramine \_\_\_\_\_\_\_\_\_\_\_\_ mg PO ⬜ 30 to 60 minutes before infusion PRN. ⬜ May repeat every \_\_\_\_\_\_\_\_ hours PRN.  ⬜ Emla® cream (30 grams). Apply topically 30 to 60 minutes prior to needle placement PRN.  ⬜ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ANAPHYLAXIS PROTOCOL: 1) Stop infusion. Call 911. 2) Administer medications below per protocol.  Epinephrine (Autoinjector 2-pack): 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) |
| NURSING / SUPPLIES / EQUIPMENT:  ☑ Nursing visits to train patient/care provider and subcutaneous immunoglobulin administration, assess, monitor patient, provide education. 1-4 skilled nursing visits for the purposes of—as with SC infusions—independent administration of nurse. PRN thereafter to refresh skills.  ☑ Infusion supplies and syringe driver/pump PRN for the administration and disposal of medication. |
| Dispense (all above): ⬜ up to 1-month supply + refills x 1 year ⬜ up to 3-month supply + refills x 1 year ⬜ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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.