



Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front &amp; Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION				
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____		Prescriber Name: _____ State License: _____ NPI #: _____ Tax ID: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____				
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)						
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____				
CLINICAL INFORMATION						
<input type="checkbox"/> D80 Immunodeficiency with predominantly antibody defects <input type="checkbox"/> G35 Multiple Sclerosis <input type="checkbox"/> G70.01 Myasthenia Gravis with (acute) exacerbation <input type="checkbox"/> Other: _____				<input type="checkbox"/> D80.1 Nonfamilial hypogammaglobulinemia <input type="checkbox"/> G61.0 Guillain-Barré Syndrome <input type="checkbox"/> M33.2 Polymyositis	<input type="checkbox"/> D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses <input type="checkbox"/> G61.81 CIDP <input type="checkbox"/> M33.90 Dermatomyositis	<input type="checkbox"/> D83.9 Common variable immunodeficiency (unspecified) <input type="checkbox"/> G70.00 Myasthenia gravis <input type="checkbox"/> M33.10 Other dermatomyositis, organ involvement unspecified
Vascular access: <input type="checkbox"/> Peripheral <input type="checkbox"/> Central <input type="checkbox"/> Port Infusion method: <input type="checkbox"/> Gravity <input type="checkbox"/> Pump						
Adverse Reactions with Previous IG treatments? <input type="checkbox"/> No <input type="checkbox"/> Yes Reason/Brand: _____						
**Obtain the following labs at prior to start of treatment and at _____ frequency: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFTs <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: _____						
TRIED AND/OR FAILED MEDICATIONS		LEGNTH OF THERAPY		REASON FOR DISCONTINUATION		
_____/_____/_____		_____/_____/_____		_____/_____/_____		
_____/_____/_____		_____/_____/_____		_____/_____/_____		
IVIG ORDERS						
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____						
Medication			Dose/Frequency			
<input type="checkbox"/> Asceniv™ 10% <input type="checkbox"/> Bivigam® 10% <input type="checkbox"/> Gammagard® liquid 10% <input type="checkbox"/> Gammagard® S/D 5% <input type="checkbox"/> Gammagard® S/D 10% <input type="checkbox"/> Gammaked™ 10% <input type="checkbox"/> Gamunex®-C 10% <input type="checkbox"/> Octagam® 5% <input type="checkbox"/> Octagam® 10% <input type="checkbox"/> Panzyga® 10% <input type="checkbox"/> Privigen® 10% <input type="checkbox"/> Non-Branded			<input type="checkbox"/> Infuse _____ grams intravenously every _____ weeks. <input type="checkbox"/> Infuse _____ g/kg intravenously every _____ weeks. <input type="checkbox"/> Infuse _____ mg/kg intravenously every _____ weeks. <input type="checkbox"/> Other: _____			
Pre-Medication	Route	Dose	Directions	Quantity	Refills	
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> By mouth	<input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____	
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> By mouth <input type="checkbox"/> IV	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____	
<input type="checkbox"/> Other: _____	_____	_____	_____	_____	#: _____	

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IV Fluids	Route	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Normal Saline 0.9% <input type="checkbox"/> ½ Normal Saline 0.45% <input type="checkbox"/> Dextrose 5% <input type="checkbox"/> Other: _____	<input type="checkbox"/> IV	_____	<input type="checkbox"/> Before each infusion <input type="checkbox"/> After each infusion	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____
<b>Flush</b>	<b>Route</b>	<b>Dose</b>	<b>Directions</b>	<b>Quantity</b>	<b>Refills</b>
<input type="checkbox"/> Normal Saline 0.9%	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5mL <input type="checkbox"/> 10mL	<input type="checkbox"/> Before and after infusion <input type="checkbox"/> Other: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____
<input type="checkbox"/> Heparin 10 units/ml <input type="checkbox"/> Heparin 100 units/ml	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5mL <input type="checkbox"/> 10mL	<input type="checkbox"/> After infusion <input type="checkbox"/> Other: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____
<b>ANAPHYLACTIC REACTION (AR):</b>					
<input type="checkbox"/> EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg); may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary <input type="checkbox"/> Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access <input type="checkbox"/> Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr <input type="checkbox"/> Other: _____					
<b>SIGNATURE</b>					
We hereby authorize Valustar to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.					
X _____ Prescriber Signature			Date: _____		

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