IVIG®

Please Fax Completed Form To: 888-898-9113

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

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

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

☐ D80 Immunodeficiency with predominantly antibody defects

☐ D80.1 Nonfamilial hypogammaglobulinemia

☐ D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses

☐ D83.9 Common variable immunodeficiency (unspecified)

☐ G35 Multiple Sclerosis

☐ G61.0 Guillain-Barré Syndrome

☐ G61.81 CIDP

☐ G70.00 Myasthenia gravis

☐ G70.01 Myasthenia Gravis with (acute) exacerbation

☐ M33.2 Polymyositis

☐ M33.90 Dermatomyositis

☐ M33.10 Other dermatomyositis, organ involvement unspecified

☐ Other: _____

Vascular access: ☐ Peripheral ☐ Central ☐ Port Infusion method: ☐ Gravity ☐ Pump

Adverse Reactions with Previous IG treatments? ☐ No ☐ Yes Reason/Brand: _____

**Obtain the following labs at prior to start of treatment and at _____ frequency: ☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ LFTs ☐ X-Ray ☐ Other: _____

TRIED AND/OR FAILED MEDICATIONS	LEGNTH OF THERAPY	REASON FOR DISCONTINUATION

IVIG ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication			Dose/Frequency
☐ Asceniv™ 10%	☐ Bivigam® 10%	☐ Gammagard® liquid 10%	☐ Infuse _____ grams intravenously every _____ weeks.
☐ Gammagard® S/D 5%	☐ Gammagard® S/D 10%	☐ Gammaked™ 10%	☐ Infuse _____ g/kg intravenously every _____ weeks.
☐ Gamunex®-C 10%	☐ Octagam® 5%	☐ Octagam® 10%	☐ Infuse _____ mg/kg intravenously every _____ weeks.
☐ Panzyga® 10%	☐ Privigen® 10%	☐ Non-Branded	☐ Other: _____

Pre-Medication	Route	Dose	Directions	Quantity	Refills
☐ Acetaminophen	☐ By mouth	☐ 325mg ☐ 500mg ☐ Other: _____	☐ Pre-Med: _____ ☐ Other: _____	☐ With Each Infusion ☐ Other: _____	#: _____
☐ Diphenhydramine	☐ By mouth ☐ IV	☐ 25mg ☐ 50mg ☐ Other: _____	☐ Pre-Med: _____ ☐ Other: _____	☐ With Each Infusion ☐ Other: _____	#: _____
☐ Other: _____	_____	_____	_____	_____	#: _____

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IV Fluids	Route	Dose	Directions	Quantity	Refills
☐ Normal Saline 0.9% ☐ ½ Normal Saline 0.45% ☐ Dextrose 5%	☐ IV	_____	☐ Before each infusion ☐ After each infusion	☐ With Each Infusion ☐ Other: _____	#: _____
☐ Other: _____	_____	_____	_____	_____	#: _____
Flush	**Route**	**Dose**	**Directions**	**Quantity**	**Refills**
☐ Normal Saline 0.9%	☐ IV	☐ 3 mL ☐ 5mL ☐ 10mL	☐ Before and after infusion ☐ Other: _____	☐ With Each Infusion ☐ Other: _____	#: _____
☐ Heparin 10 units/ml ☐ Heparin 100 units/ml	☐ IV	☐ 3 mL ☐ 5mL ☐ 10mL	☐ After infusion ☐ Other: _____	☐ With Each Infusion ☐ Other: _____	#: _____

ANAPHYLACTIC REACTION (AR):

☐ 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

☐ 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

☐ Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary

☐ Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access

☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr

☐ Other: _____

SIGNATURE

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_____ Date: _____

Prescriber Signature