

PATIENT INFORMATION (Complete or Fax Existing Chart)			PRESCRIBER INFORMATION		
Name: _____ DOB: _____			Prescriber Name: _____		
Address: _____			State License: _____		
City, State, Zip: _____			NPI #: _____ DEA: _____		
Phone: _____ Alt. Phone: _____			Address: _____		
Email: _____ SS#: _____			City, State, Zip: _____		
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____			Phone: _____ Fax: _____		
Allergies: _____			Office Contact: _____ Phone: _____		
INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)					
Primary Insurance: _____			RX Card (PBM): _____		
City, State, Zip: _____			BIN: _____ PCN: _____		
Plan #: _____			City, State, Zip: _____		
Group #: _____			Group #: _____		
Phone: _____			Phone: _____		
CLINICAL INFORMATION					
<input type="checkbox"/> D80.0 Congenital Hypogammaglobinemia			<input type="checkbox"/> D81.9 SCID (unspecified)		
<input type="checkbox"/> G35 MS (Relapsing Remitting)			<input type="checkbox"/> G61.0 GBS		
<input type="checkbox"/> G61.89 MMN			<input type="checkbox"/> G70.01 MG W/ acute exacerbation		
<input type="checkbox"/> M33.90 Dermatomyositis			<input type="checkbox"/> D83.9 Common Variable Immunodeficiency		
<input type="checkbox"/> Other Code: _____ Description: _____			<input type="checkbox"/> M33.20 Polymyositis		
Needs by date: _____			Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> Other: _____		
(DRUG NAME) ORDERS – this section may not be needed)					
Medication	Route	Dose	Directions	Quantity	Refills
Immune Globulin Brand (any): <input type="checkbox"/> Dispense as written	<input type="checkbox"/> IV <input type="checkbox"/> SC <input type="checkbox"/> IM	_____ grams _____ g/kg	IV or Sub - _____ gm once daily for _____ days Repeat every _____ week for total of _____ Course/Courses		
Pre-Medications	Route	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 325 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> _____ mg	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> _____	<input type="checkbox"/> w/ ea. Infusion	
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> PO <input type="checkbox"/> IM <input type="checkbox"/> IV	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> PRN Reaction: _____	<input type="checkbox"/> w/ ea. Infusion	
<input type="checkbox"/> Methylprednisone					
<input type="checkbox"/> Ondansetron					
<input type="checkbox"/> Reglan					
<input type="checkbox"/> Other					
Flush	Route	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Saline 10mL	<input type="checkbox"/> IV	<input type="checkbox"/> 3mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> Before and after infusion <input type="checkbox"/> _____	<input type="checkbox"/> w/ ea. Infusion	
<input type="checkbox"/> Heparin 10 units/mL <input type="checkbox"/> Heparin 100 units/mL	<input type="checkbox"/> IV	<input type="checkbox"/> 3mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> After infusion <input type="checkbox"/> _____	<input type="checkbox"/> w/ ea. Infusion	
Anaphylaxis	Route	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> IV <input type="checkbox"/> PO <input type="checkbox"/> IM	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> _____	<input type="checkbox"/> Pre-med: _____ <input type="checkbox"/> _____	<input type="checkbox"/> w/ ea. Infusion <input type="checkbox"/> _____	
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> IM <input type="checkbox"/> SQ	<input type="checkbox"/> Adult: 1:1000 0.3 mL <input type="checkbox"/> Peds 1:2000 0.3 mL	<input type="checkbox"/> PRN Anaphylaxis <input type="checkbox"/> Repeating Dose: _____	<input type="checkbox"/> Once <input type="checkbox"/> _____	
<input type="checkbox"/> EpiPen (2 pack)	<input type="checkbox"/> IM <input type="checkbox"/> SQ				
<input type="checkbox"/> Other					
Vascular Access Method: <input type="checkbox"/> Peripheral <input type="checkbox"/> Central <input type="checkbox"/> Other _____					
SIGNATURE					
X _____			Date: _____		
Prescriber Signature					

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