

| 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):<br><input type="checkbox"/> Dispense as written   | <input type="checkbox"/> IV <input type="checkbox"/> SC <input type="checkbox"/> IM | _____ grams   | IV or Sub - _____ gm once daily for _____ days<br>Repeat every _____ week for total of _____ Course/Courses |  |         |
|  |   | _____ g/kg  |   |  |         |
| 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: _____<br><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: _____<br><input type="checkbox"/> PRN Reaction: _____                     | <input type="checkbox"/> w/ ea. Infusion                                   |         |
| <input type="checkbox"/> Methylprednisolone  |   |   |   |  |         |
| <input type="checkbox"/> Odansetron  |   |   |   |  |         |
| <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<br><input type="checkbox"/> _____      | <input type="checkbox"/> Before and after infusion<br><input type="checkbox"/> _____                        | <input type="checkbox"/> w/ ea. Infusion                                   |         |
| <input type="checkbox"/> Heparin 10 units/mL<br><input type="checkbox"/> Heparin 100 units/mL  | <input type="checkbox"/> IV   | <input type="checkbox"/> 3mL <input type="checkbox"/> 5 mL<br><input type="checkbox"/> _____      | <input type="checkbox"/> After infusion<br><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: _____<br><input type="checkbox"/> _____                                   | <input type="checkbox"/> w/ ea. Infusion<br><input type="checkbox"/> _____ |         |
| <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> IM <input type="checkbox"/> SQ                             | <input type="checkbox"/> Adult: 1:1000 0.3 mL<br><input type="checkbox"/> Peds 1:2000 0.3 mL      | <input type="checkbox"/> PRN Anaphylaxis<br><input type="checkbox"/> Repeating Dose: _____                  | <input type="checkbox"/> Once<br><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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