



IVIG Intake Form

Northborough, MA: Toll free (855) 880-1091 Toll free fax (844) 265-0265

www.AllCarePlusPharmacy.com

PATIENT INFORMATION	
Patient Name	
Address	
City, State, Zip	
Phone	
Social Security	
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

PRESCRIBER INFORMATION		
Prescriber Name		
Address		
City, State, Zip		
Phone	Fax	Email
Preparer Name/Office Contact		Preferred Contact Method <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email
DEA/NPI #		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

<p>Primary Diagnosis & ICD-10 Code: _____</p> <p>Date of diagnosis: _____</p> <p>IgA deficiency: <input type="checkbox"/> Yes <input type="checkbox"/> No IgA level _____ mg/dL Date: _____</p> <p>IgG trough: _____ mg/dL Date: _____ Diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comorbidities: _____</p> <p>Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____</p>	<p>Access: <input type="checkbox"/> Peripheral Butterfly</p> <p>Phylaxis: <input type="checkbox"/> PICC <input type="checkbox"/> Implant Port <input type="checkbox"/> Broviac®/ Hickman®</p> <p>Confirmation of Distal Tip Placement? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____</p> <p>Has patient received immune globulin previously? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, product information: _____</p> <p>Date of last infusion: _____ Date of next infusion: _____</p> <p>Weight: _____ Height: _____</p>
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ORDER INFORMATION

Intravenous Immune Globulin Products	<input type="checkbox"/> Bivigam®10% <input type="checkbox"/> Carimune®NF <input type="checkbox"/> Flebogamma®5% <input type="checkbox"/> Flebogamma®10%
	<input type="checkbox"/> GammaKed®10% <input type="checkbox"/> Gammagard®Liquid10% <input type="checkbox"/> Gammaplex®5% <input type="checkbox"/> Gammagard®S/D
	<input type="checkbox"/> Gamunex-C®10% <input type="checkbox"/> Octagam®5% <input type="checkbox"/> Octagam®10% <input type="checkbox"/> Privigen®10% <input type="checkbox"/> IVIG
Subcutaneous Immune Globulin Products	<input type="checkbox"/> Hizentra® 20% <i>Weekly Sub-Q dose = IVIG Dose (g) x 1.37 / IVIG weekly interval originally given</i> <input type="checkbox"/> HyQvia® 10%
Therapy Regimen	Dose: _____ g/kg Total dose: _____ grams Daily for _____ days every _____ weeks # Doses: _____ Refills: _____ Administration Rate: <input type="checkbox"/> Per manufacturer guidelines, as tolerated <input type="checkbox"/> _____
Pre-Medications and Pre-Protocol	<input type="checkbox"/> Diphenhydramine _____ mg 30 min before infusion <input type="checkbox"/> PO <input type="checkbox"/> IVP <input type="checkbox"/> Hydration Infuse _____ mL _____ solution <input type="checkbox"/> Prior <input type="checkbox"/> During <input type="checkbox"/> Following <input type="checkbox"/> Acetaminophen _____ mg 30 min before infusion PO <input type="checkbox"/> Solu-Cortef® _____ mg slow IVP <input type="checkbox"/> Other: _____ <input type="checkbox"/> Solu-Medrol® _____ mg slow IVP <input type="checkbox"/> Other: _____ <input type="checkbox"/> Pre <input type="checkbox"/> Halfway <input type="checkbox"/> Upon completion
Flushing Protocol	<input type="checkbox"/> Sodium Chloride 0.9% 5-10 mL pre and post medications <input type="checkbox"/> Heparin _____ Units/mL _____ mL as needed
Anaphylaxis Orders and Medications	Orders: 1. Stop infusion 2. Call 911 and prescribing physician 3. Administer medications below as per protocol
	<input type="checkbox"/> Diphenhydramine Administer 25-50 mg slow IV/IM Dispense: 1 x 50 mg vial
	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Administer 0.3 mg (1:1000) Sub-Q (≥ 30 Kg) <input type="checkbox"/> Administer 0.15 mg (1:2000) Sub-Q (< 30 Kg) Dispense: 1 vial
	<input type="checkbox"/> Sodium Chloride 0.9% Use as directed per the protocol Dispense: 1 x 500 mL Bag
Ancillary Supplies	<input type="checkbox"/> As needed for proper administration and disposal of medication
Skilled Nursing Visits	<input type="checkbox"/> As needed for IV access, administration and proper clinical monitoring
Administration procedures to be followed per pharmacy protocol.	

Physician Signature: _____ Date: _____

I authorize AllCare Plus Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. In no event should the material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. This is a patient enrollment form for the above mentioned therapies. Patients have the right to use the Pharmacy of their choice, if AllCare Plus Pharmacy is the Pharmacy of choice, please follow up with a call in, electronic, faxed or mailed prescription to AllCare Plus Pharmacy, 50 Bearfoot Road, Northborough, MA 01532. (Phone) 1 855 880 1091 (Fax) 1 844 265 0265