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 ◯ Male ◯ Female

PRESCRIBER INFORMATION

Prescriber Name

Address

City, State, Zip

Phone Fax Email

Preparer Name/Office Contact Preferred Contact Method ☐ Phone ☐ Fax ☐ Email

DEA/NPI #

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

CLINICAL INFORMATION

Primary Diagnosis & ICD-10 Code: _____

_____

Date of diagnosis: _____

IgA deficiency: ◯ Yes ◯ No IgA level _____ mg/dL Date: _____

IgG trough: _____ mg/dL Date: _____ Diabetic: ◯ Yes ◯ No

Comorbidities: _____

Allergies: ◯ NKDA ◯ Other: _____

Access: ☐ Peripheral Butterfly

Phylaxis: ☐ PICC ☐ Implant Port ☐ Broviac®/ Hickman®

Confirmation of Distal Tip Placement? ☐ Yes ☐ No Date: _____

Has patient received immune globulin previously? ☐ Yes ☐ No

If yes, product information: _____

Date of last infusion: _____ Date of next infusion: _____

Weight: _____ Height: _____

ORDER INFORMATION

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