Immune Globulin 10%

Alyglo, Asceniv, Gamunex-C, Gammagard, Privigen, Bivigam, Octagam, Panzyga

INFUSION FOR HEALTH

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Insurance Information, All Clinical Documentation Supporting the Diagnosis Including any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing, Most Recent Office Visit Note, Recent Labs (CMP)

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal ☐ Home Infusion

Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ D80. ___ ☐ D83. ___ ☐ G61.8___ ☐ M33.10 ☐ D69.3 ☐_____ ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ IgA/IgG levels ☐ at each dose ☐ every _____

☐ Other: _____ ☐ Frequency: _____

☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

☑ Immune Globulin 10%
I4H will administer 10% unless otherwise specified

Dose: ☐ _____ g/kg
☐ _____ mg/kg
☐ _____ grams (fixed dose)

Route: ☐ IV / ☐ SQ
Only Gamunex-C and Gammagard are available for SQ administration

Frequency: ☐ _____

Preferred Brand: ☐ _____
To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS:

Provider Name (Print) Provider Signature Date

☐ ***Please check this box if you DO NOT authorize Infusion for Health to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***