IVIG ORDER

FAX: 800-987-6552
Phone: 877-283-8679

PATIENT INFORMATION

Patient Name:	Ship to: ☐ Home ☐ Office		DOB:	
Home Address:	City:		State:	Zip:
Home Phone:	Height:	Weight:	Gender: ☐ Male ☐ Female	
Cell Phone:	Email Address:			

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance Co:	Policy Holder:	Relationship:	Policy#:	Group#:
Secondary Insurance:	Policy Holder:	Relationship:	Policy#:	Group#:

CLINICAL INFORMATION (fax all pertinent clinical and lab information)

Diagnosis (ICD-10)	Date of Diagnosis:		
Has patient received immune globulin previously? ☐ Yes ☐ No	Date of last infusion:	Date of next infusion:	Access: ☐ PIV ☐ PICC ☐ PORT

Check all that apply: ☐ HTN ☐ Heart Failure ☐ IgA < 5-7 mg/dL ☐ Diabetes ☐ Renal Issues ☐ History of Thrombosis

List additional comorbidities: Allergies:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Immune Globulin Products	☐ IVIG (pharmacist to determine appropriate product based on clinical risk assessment, insurance requirements and availability.) **OR** ☐ Enter Preferred Brand Name Here:
Therapy Regimen	Dose:_____g/kg Total Dose:_____grams Daily for _____ days every_____weeks May Adjust infusion schedule within +/- 7 days if nursing or patient need arises (with payer approval) Quantity to Dispense:_____ doses Refills:_____ Administration Rate: ☐ Per Manufacture guidelines, as tolerated ☐ _____ ☐ Check here if you would like Adjusted Body Weight used for dosing (if patient > 100kg)
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 to ☐ Following ☐ Prior to AND following ☐ Heparin 10 u/ml Peripheral Line: 3 ml after last NaCl 0.9% flush and prn ☐ Heparin 100 u/ml Central Line: 5ml after last NaCl 0.9% flush and prn
Flushing Protocol	☐ Sodium Chloride 0.9% 5-10 mL pre and post medication and prn

The quantity and refills for pre-treatment and flushing protocol medications will match the immune globulin administration requirements.

Anaphylaxis Orders and Medications	☐ Provide anaphylaxis kit per attached protocol.
Pump and Ancillary Supplies	☐ Pump and supplies as needed for administration and appropriate disposal of infusion materials.
Skilled Nursing Orders and Plan of Treatment	☐ Provide Skilled Nursing for home infusion per attached protocol. ☐ In-office infusion; no nursing needed.

Administration procedures to be followed per pharmacy protocol.

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution.	☐ Dispense as written	

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email Address:	
Address:		
NPI:		

Prescriber Signature: Date:

Your signature authorizes AvevoRx, LLC and their network of pharmacies, Mid-Valley Health System (the "AvevoRx Pharmacies"), to act on your behalf to obtain prior authorization, including appeals and peer to peer reviews, for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.