



IVIG ORDER

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

PATIENT INFORMATION

Patient Name:	Ship to: <input type="checkbox"/> Home <input type="checkbox"/> Office	DOB:
Home Address:	City:	State: Zip:
Home Phone:	Height: Weight:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last infusion: Date of next infusion: Access: <input type="checkbox"/> PIV <input type="checkbox"/> PICC <input type="checkbox"/> PORT
Check all that apply: <input type="checkbox"/> HTN <input type="checkbox"/> Heart Failure <input type="checkbox"/> IgA < 5-7 mg/dL <input type="checkbox"/> Diabetes <input type="checkbox"/> Renal Issues <input type="checkbox"/> History of Thrombosis	
List additional comorbidities:	Allergies:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Immune Globulin Products	<input type="checkbox"/> IVIG (pharmacist to determine appropriate product based on clinical risk assessment, insurance requirements and availability.) OR	
	<input type="checkbox"/> 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: <input type="checkbox"/> Per Manufacture guidelines, as tolerated <input type="checkbox"/> _____ <input type="checkbox"/> Check here if you would like Adjusted Body Weight used for dosing (if patient > 100kg)	
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"/> Acetaminophen _____ mg 30 min before infusion PO <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Hydration Infuse _____ mL _____ solution <input type="checkbox"/> Prior to <input type="checkbox"/> Following <input type="checkbox"/> Prior to AND following <input type="checkbox"/> Heparin 10 u/ml Peripheral Line: 3 ml after last NaCl 0.9% flush and prn <input type="checkbox"/> Heparin 100 u/ml Central Line: 5ml after last NaCl 0.9% flush and prn
Flushing Protocol	<input type="checkbox"/> 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	<input type="checkbox"/> Provide anaphylaxis kit per attached protocol.
Pump and Ancillary Supplies	<input type="checkbox"/> Pump and supplies as needed for administration and appropriate disposal of infusion materials.
Skilled Nursing Orders and Plan of Treatment	<input type="checkbox"/> Provide Skilled Nursing for home infusion per attached protocol. <input type="checkbox"/> 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.	<input type="checkbox"/> Dispense as written
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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.

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