



SCIG 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)	Current regimen if applicable:
Has patient received immune globulin previously? <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of last infusion:
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 Product	<input type="checkbox"/> SCIG (pharmacist to determine appropriate product based on clinical risk assessment, insurance formulary and availability.) OR <input type="checkbox"/> Enter Preferred Brand Name Here:
Therapy Regimen	<input type="checkbox"/> ___ grams subcutaneously every ___ week(s), OR <input type="checkbox"/> Convert from current IVIG dose of ___ grams every ___ weeks, OR CIDP Dosing: <input type="checkbox"/> 0.2 grams/kg subcutaneously every week, OR <input type="checkbox"/> 0.4 grams/kg subcutaneously every week
	Dispense quantity sufficient for 4-week supply Refills: _____
	Administration Rate: <input type="checkbox"/> Per Manufacture guidelines, as tolerated, OR <input type="checkbox"/> Using ___ subcutaneous site(s) over ___ minutes.
	Preferred needle length: <input type="checkbox"/> 6 mm <input type="checkbox"/> 9 mm <input type="checkbox"/> 12 mm
	Pre-Medications
	<input type="checkbox"/> Acetaminophen ___ mg PO 30 minutes before infusion <input type="checkbox"/> Diphenhydramine ___ mg PO 30 minutes before infusion <input type="checkbox"/> Lidocaine 4% Cream, 30 grams: apply topically to injection site(s) 30 minutes before infusion <input type="checkbox"/> Other: _____ <input type="checkbox"/> No pre-meds needed

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

Anaphylaxis Order	<input type="checkbox"/> Epinephrine 0.3mg auto-injector (2-pack) IM PRN, OR <input type="checkbox"/> Epinephrine 0.15 mg auto-injector (2-pack) IM PRN
Pump and Ancillary Supplies	<input type="checkbox"/> Provide syringe pump and supplies as needed for administration and appropriate disposal of infusion materials.
Skilled Nursing Orders	<input type="checkbox"/> Provide Skilled Nursing for home self-infusion training.
	<input type="checkbox"/> Patient is independent with self-infusion and no nursing services required.

Administration procedures to be followed per pharmacy protocol. Larger SCIG doses may be divided over 1-2 days, as tolerated.

As required by your state, Prescriber to check "Dispense as written" or handwritten "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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