SCIG 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)	Current regimen if applicable:
Has patient received immune globulin previously? ☐ No ☐ Yes	Date of last infusion:

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 Product	☐ SCIG (pharmacist to determine appropriate product based on clinical risk assessment, insurance formulary and availability.) **OR**
	☐ Enter Preferred Brand Name Here:
Therapy Regimen	☐ ____ grams subcutaneously every ____ week(s), **OR**
	☐ Convert from current IVIG dose of ____ grams every ____ weeks, **OR**
	CIDP Dosing: ☐ 0.2 grams/kg subcutaneously every week, **OR** ☐ 0.4 grams/kg subcutaneously every week
	Dispense quantity sufficient for 4-week supply Refills:_____
	Administration Rate: ☐ Per Manufacture guidelines, as tolerated, **OR** ☐ Using ____ subcutaneous site(s) over ____ minutes.
	Preferred needle length: ☐ 6 mm ☐ 9 mm ☐ 12 mm
Pre-Medications	☐ Acetaminophen _____ mg PO 30 minutes before infusion
	☐ Diphenhydramine _____ mg PO 30 minutes before infusion
	☐ Lidocaine 4% Cream, 30 grams: apply topically to injection site(s) 30 minutes before infusion
	☐ Other: _____
	☐ No pre-meds needed

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

Anaphylaxis Order	☐ Epinephrine 0.3mg auto-injector (2-pack) IM PRN, **OR** ☐ Epinephrine 0.15 mg auto-injector (2-pack) IM PRN
Pump and Ancillary Supplies	☐ Provide syringe pump and supplies as needed for administration and appropriate disposal of infusion materials.
Skilled Nursing Orders	☐ Provide Skilled Nursing for home self-infusion training.
	☐ 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 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.