

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List 6. Current IG Levels

PRIMARY DIAGNOSIS

<input type="checkbox"/> C91.0 Acute lymphoblastic leukemia [ALL]	<input type="checkbox"/> G35 Multiple sclerosis	<input type="checkbox"/> M33.20 Polymyositis, organ involvement unspecified
<input type="checkbox"/> D80.1 Nonfamilial hypogammaglobulinemia	<input type="checkbox"/> G61.81 Chronic inflammatory demyelinating polyneuritis	<input type="checkbox"/> M33.22 Polymyositis with myopathy
<input type="checkbox"/> D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses	<input type="checkbox"/> G61.82 Multifocal motor neuropathy	<input type="checkbox"/> M33.90 Dermatopolymyositis, unspecified, organ involvement unspecified
<input type="checkbox"/> D80.9 Immunodeficiency with predominantly antibody defects, unspecified	<input type="checkbox"/> G70.00 Myasthenia gravis without (acute) exacerbation	<input type="checkbox"/> M72.6 Necrotizing fasciitis
<input type="checkbox"/> D83.0 Com variable immunodeficiency w/ predominant abn of B-cell num & function	<input type="checkbox"/> G70.01 Myasthenia gravis with (acute) exacerbation	<input type="checkbox"/> T86.10 Unspecified complication of kidney transplant
<input type="checkbox"/> D83.1 Com variable immunodeficiency w/ predominant immunoreg T-cell disorder	<input type="checkbox"/> G72.49 Oth inflammatory and immune myopathies, NEC	<input type="checkbox"/> T86.11 Kidney transplant rejection
<input type="checkbox"/> D83.9 Common variable immunodeficiency, unspecified	<input type="checkbox"/> J84.9 Interstitial pulmonary disease, unspecified	<input type="checkbox"/> Z94.0 Kidney transplant status
	<input type="checkbox"/> L10.0 Pemphigus vulgaris	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> M33.13 Other dermatomyositis without myopathy	

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

Per infusion clinic protocol: There are no recommended standard pre-meds
 Provider Prescribed: _____

PRIMARY MEDICATION ORDER

No Brand Preference:	If Brand Preference:	
<input type="checkbox"/> No brand preference - Immune Globulin Solution 5%	<input type="checkbox"/> Gamunex-C 10%	<input type="checkbox"/> Gammagard Liquid 10%
<input type="checkbox"/> No brand preference - Immune Globulin Solution 10%	<input type="checkbox"/> Privigen 10%	<input type="checkbox"/> Bivigam 10%
<input type="checkbox"/> Octagam 5%	<input type="checkbox"/> Octagam 10%	
<input type="checkbox"/> Panzyga 10%	<input type="checkbox"/> _____	

Dosing: _____ GRAMS/kg or _____ GRAMS IV divided equally over _____ days every _____ weeks
 _____ milligrams/kg or _____ milligrams IV divided equally over _____ days every _____ weeks
 Other _____

FIRST DOSE?: Yes No Refill x12 months unless otherwise noted.

*Dose will be rounded to the nearest 5g vial size. To prohibit dose rounding, check here

LINE USE/CARE ORDERS

Start PIV/ACCESS CVC Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X

PROVIDER SIGNATURE _____ DATE _____