



Patient information		Prescriber + Shipping Information	
Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ 1° Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate Phone: _____ Caregiver name: _____ Relation: _____ Local Pharmacy: _____ Phone: _____	Prescriber Name: _____ NPI #: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address: _____ If shipping to prescriber: <input type="checkbox"/> 1st Fill <input type="checkbox"/> Always <input type="checkbox"/> Never		
Insurance Information (Please fax a copy of front and back of the insurance cards)			
1° Insurance Plan: _____ Plan ID # _____	Policy Holder: _____	Relation: _____	
2° Insurance Plan: _____ Plan ID # _____	Policy Holder: _____	Relation: _____	
Clinical Information (Please fax all pertinent clinical and lab information)			
ICD-10/Diagnosis Code: _____ Date of Diagnosis: _____ Has patient received immune globulin previously? <input type="checkbox"/> Yes <input type="checkbox"/> No IgA deficiency: <input type="checkbox"/> Yes <input type="checkbox"/> No IgA level _____ mg/dL Date: _____ If yes, product information: _____ IgG trough: _____ mg/dL Date: _____ Diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last infusion: _____ Date of next infusion: _____ Comorbidities: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			
Prescription			
Immune Globulin Products	<input type="checkbox"/> Hizentra® 20% <i>Weekly Sub-Q dose = IVIG Dose (g) x 1.37 / IVIG weekly interval originally given</i>		
	<input type="checkbox"/> HyQvia® 10% Complete the Mylg source form at http://www.myigsource.com/pdf/Baxalta_Rx_Forms.pdf for orders and patient registration.		
	<input type="checkbox"/> GammaKed™ 10% <input type="checkbox"/> Gammagard liquid® 10% <input type="checkbox"/> Gamunex-C® 10% <i>Weekly Sub-Q dose = IVIG Dose (g) x 1.53 / IVIG weekly interval originally given</i>		
Therapy Regimen	Dose: _____ grams _____ times weekly # Doses: _____ Refill: _____ Administration rate and number of sites: <input type="checkbox"/> Per manufacture guidelines, as tolerated <input type="checkbox"/> _____		
Other Medications	<input type="checkbox"/> Acetaminophen Take _____ mg by mouth every 4-6 hours as needed for fever and/or headache <input type="checkbox"/> Diphenhydramine Take _____ mg by mouth every 4-6 hours as needed for itching Drug: _____ Strength: _____ Qty: _____ Directions: _____ Refills: _____		
Anaphylaxis Orders and Medications	Orders: 1. Stop infusion 2. Call 911 and prescribing physician 3. Administer medications below as per protocol <input type="checkbox"/> Epinephrine <input type="checkbox"/> EpiPEN® - Administer 0.3 mg (1:1000) subcutaneously as needed (≥ 30 Kg or ≥ 66 lbs) <input type="checkbox"/> EpiPEN Jr® - Administer 0.15 mg (1:2000) subcutaneously as needed (< 30 Kg or < 66 lbs) Qty: _____ Refill: _____		
Ancillary Supplies	<input type="checkbox"/> As needed for proper administration and disposal of medication		
Skilled Nursing Visits	<input type="checkbox"/> To train patient/caregiver in Subcutaneous Immune Globulin administration, provide education related to disease state/therapy and assess general status. Typically 3 training visits required. Once trained and able to return demonstrate, patient/caregiver to self-adminster Subcutaneous Immune Globulin medication independently		
Administration procedures to be followed per pharmacy protocol.			
Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____			
Prescriber's Signature: _____ Date: _____			

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.