Immune Globulin Order Form
(SubQ Infusion)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ D80._____ Hypogammaglobulinemia
☐ D80.2_____ Select IG Deficiency
☐ D83._____ Common Variable Immune Deficiency
Other: _____

Prescribing Information

- IVIG product will be based on supply and availability, unless specified.

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

PRESCRIPTION

Immune Globulin SubQ Infusion

☐ **HIZENTRA**

SubQ: Infuse _____ grams every _____ weeks for one year

Quantity to be Dispensed: _____ grams per month for one year

<<<<PRESCRIBER MUST COMPLETE QUANTITY TO BE DISPENSED & NUMBER OF REFILLS>>>>

☐ OTHER: _____

SubQ: Infuse _____ grams every _____ weeks for one year

Quantity to be Dispensed: _____ grams per month for one year

<<<<PRESCRIBER MUST COMPLETE QUANTITY TO BE DISPENSED & NUMBER OF REFILLS>>>>

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first infusion.

Home Infusion Patient Orders Only

Administer by Syringe Pump (Ambulatory Infusion Pump, Mechanical, Reusable, for subcutaneous infusion – E0779).
Dispense supplies for external drug infusion pump, syringe type cartridge, sterile, each (K0552).

Comments: _____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ ***Signature:*** _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip:_____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____