medix infusion

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: ______

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 >>>>

☐ **XEMBIFY**
SubQ: Infuse ______ grams every ______ days 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 >>>>

Post Treatment Observations: The patient is observed for 30 minutes following the first infusion.
Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

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:** ______