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: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

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>>>>

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No
If yes, please note therapy and last dose: _____

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

Home Infusion Patient Orders Only
Administer by Syringe Pump (Ambulatory Infusion Pump, Mechanical, Reusable, for subcutaneous infusion - E0779).
Dispense supplies for external drug infustion 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: _____