Immune Globulin Order Form
(SubQ infusion)

medix infusion

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Phone: _____ Sex: ☐ M ☐ F

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (Required)
☐ _____

ICD 10 Description
☐ _____

Weight: _____ ☐ lb ☐ kg Height: _____

Patient Status:
☐ New to therapy
☐ Continuing therapy (date of last dose _____)

Allergies: _____

PRESCRIPTION

IMMUNE GLOBULIN (SubQ Infusion)

☐ **HIZENTRA** ☐ **HYQVIA** ☐ **XEMBIFY** ☐ **OTHER** _____

SubQ: Infuse _____ grams every _____ weeks for one year

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

Number of Refills: _____

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**

Is yes, please note therapy and last dose: _____

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

Other Orders:

_____

_____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list

Supporting Clinical Notes:
Include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: _____

Signature: _____

NPI #: _____ Date: _____

Supervising Physician (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____