



# Immune Globulin® Order Form (SCIg Infusion)

FAX TO: 972.499.9210

## Patient Information

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex: M F

## Diagnosis

### ICD 10 Code (Required)

\_\_\_\_\_

### ICD 10 Description

\_\_\_\_\_

Weight: \_\_\_\_\_ lb kg Height: \_\_\_\_\_

### Patient Status:

New to therapy  
Continuing therapy (date of last dose \_\_\_\_\_ )

Allergies: \_\_\_\_\_

## Infusion Orders

### IMMUNE GLOBULIN (SubQ Infusion)

Pharmacist will determine appropriate product based on clinical assessment, insurance requirements and availability OR Preferred Brand \_\_\_\_\_

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

If 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 Clinical Documentation

- 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*

## Referring Patient Information

Prescriber Name: \_\_\_\_\_

Signature: \_\_\_\_\_

NPI #: \_\_\_\_\_ Date: \_\_\_\_\_

Supervising Physician (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_