

Customer Information

Customer Name: _____
 Date of Birth: _____ Sex: M or F Caregiver: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____ E-mail: _____
 Please attach copy of front and back of customer's prescription insurance card(s) if applicable
 Insurance Company Name: _____
 Insurance Company Phone: _____
 Policy holder: _____
 Policy holder Employer: _____
 Relationship to Customer: _____
 ID# _____ Group# _____
 RxBIN: _____ RxPCN: _____

Clinical Information and Prescription

Primary Diagnosis (ICD10): ____ . ____ Description: _____
 Secondary Diagnosis (ICD10): ____ . ____ Description: _____
 Height: _____ inches/cm Weight: _____ lb/kg Date of Measurement: ____/____/____
 Allergies: _____
 Which antibody is deficient? IgG IgA IgM
 If diagnosis of CIDP: 1. Has a Baseline neurological exam been provided? Yes No
 2. Does patient have weakness in all 4 limbs accompanied by numbness, impaired proprioception, and ataxia? Yes No
 Has the patient tried and failed prophylactic antibiotics prior to immune globulin? Yes No
 Current Medications: _____
 Vascular Access: Peripheral IV Port-a-cath PIC Central line Other: _____
 Administration by: Patient Caregiver Nursing Agency Other: _____
 Agency nurse to visit home for injection: No Yes: Agency Name / Phone: _____
Date of First/Next Injection: ____/____/____ **Date of Last Injection:** ____/____/____

Prescriber Information

Practice/ Organization Name: _____
 Prescriber Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone#: _____ Fax#: _____
 DEA# _____ NPI# _____
 License#: _____ Medicaid UPIN#: _____
 Physician Specialty: _____
Date Shipment Needed: _____
Ship to: Patient Prescriber Other: _____
 Shipment Address: _____ Attn: _____
 City: _____ State: _____ Zip: _____
If shipped to the prescriber's office, Prescriber accepts on behalf of patient for administration in office.

IVIg lyophilized -No brand preference
 IVIg lyophilized -Brand Preferred: _____
 IVIg / SCIg non-lyophilized -No brand preference
 IVIg / SCIg non-lyophilized -Brand Preferred: _____

Route of Administration: IV SC IM
Dose: _____ grams per dose x _____ days x _____ weeks
 Additional Directions: _____
 Total Quantity per Dispense: _____

Flush Protocol: _____

Ancillary medications:

Drug	Strength	Directions	Quantity	Refills
Diphenhydramine				
Acetaminophen				
Epinephrine				

Supplies requested: _____

Refills Authorized: 0 1 2 3 6 mos 1 yr Other: _____

Prescriber Signature: X _____ Date: ____/____/____

Privacy & Confidentiality of Information Notice: This communication may contain non-public, confidential, or legally privileged information intended for the sole use of the designated recipient(s). If you are not the intended recipient, or have received this communication in error, please notify the sender immediately by reply email or by telephone at the number stated above and delete all copies of this communication, including any attachments, without reading them or saving them to disk. If you are the intended recipient, you must secure the contents of this communication in accordance with all applicable state or federal requirements related to the privacy and confidentiality of information, including the HIPAA Privacy guidelines.