PREMIER PHARMACY SERVICES

Immune Globulin – Auto Immune Disorder RX Order Form

Fax: 888.270.2952
Phone: 512.461.4741

DELIVER TO: ☐ Patient's Home ☐ Prescriber's Office ☐ Other:_____ ☐ HOLD SHIPMENT

PATIENT INFORMATION

Last Name: _____

First Name: _____

S.S. #:_____ Date of Birth:_____

Sex: ☐ Male ☐ Female Height:_____ Weight:_____ lbs. ☐ kg. ☐

Allergies: _____

Home Phone:_____ Work/Mobile Phone:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Guardian/Caregiver:_____

PRESCRIBER INFORMATION

Prescriber Name:_____ ☐ MD ☐ DO ☐ NP ☐ PA

Practice Name: _____

Address:_____

City: _____ State:_____ Zip:_____

License #:_____ NPI #:_____ DEA #:_____

Phone:_____ Fax:_____

Office Contact:_____ Phone:_____

Collaborating Physician:_____

Please fax FRONT and BACK copy of ALL insurance cards – Prescription & Medical, most recent clinical assessment notes, and current medication list

PRIMARY DIAGNOSIS

☐ G61.0 Acute Infective Polynueritis (Guillain-Barre Syndrome)
☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy
☐ G70.01 Myasthenis Gravis w/ Exacerbation
☐ Other: _____

PRE-TREATMENT

☐ Tylenol 325 mg po 15-30 min. prior to starting infusion
☐ Aspirin 325 mg po 15-30 min. prior to starting infusion
☐ Benadryl 25 mg po 15-30 min. prior to starting infusion
☐ Hydration: Normal Saline 0.9% to be infused daily with IVIG
☐ 500 ml ☐ 1000 ml
☐ Other: _____

ADMINISTER IVIG

Product: ☐ **Formulation** _____ **or** ☐ **Pharmacist to determine**

Dose: (please select one and provide complete information)

☐ 2g/kg over _____ days, repeat course every _____ week(s) for _____ cycle(s)

☐ _____ mg/kg or _____g every _____ week(s) for _____ cycle(s)

☐ Other Regimen: _____

Is this the first dose? ☐ **Yes** ☐ **No** **If No, date first dose given:**_____ **Next dose due:**_____

Infusion Rate: Infuse per Premier Home Infusion of Immune Globulin policy

Infusion Reaction: Per Premier Patient Infusion reaction policy

Access: ☐ **Peripheral** ☐ **PICC** ☐ **Port** ☐ **Other:** _____

Flushing: **Premier Pharmacy Protocol (heparin 100 unit/ml, 0.9% NaCL, D5W**

Anaphylaxis/Infusion Reaction kit will contain the following (1 each):

Diphenhydramine 25 mg capsule and 50 mg/ml 1 ml vial
Epinephrine Pen 1:1000, 0.9% NaCL 500 ml bag

Prescriber Signature: Prescriber, please sign and date below.

No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.

Prescriber Signature-Substitution Permissible | Date | Prescriber Signature-Dispense as Written | Date

I authorize Premier Pharmacy Services to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.