meijer specialty pharmacy

P: 1-855-263-4537 • F: 1-877-222-5036
www.MeijerSpecialtyPharmacy.com

IV Immunoglobulin Therapy

Physician Information

Send updates to: ◯ Fax: _____ ◯ Email: _____ ◯ Text: _____

Prescriber Name:		◯MD ◯DO ◯NP ◯PA	NPI:
Office Contact:	Practice Name / Supervising MD:		
Address:	City:		
State:	Zip:	Phone:	Fax:

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic: ◯ Y ◯ N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯ Y ◯ N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code:					Date of Diagnosis: / /	
Access: ◯ Peripheral Butterfly ◯ PICC ◯ Implant Port ◯ Broviac®/Hickman®		IgA deficiency: ◯ Y ◯ N	IgA level mg/dL	Date: / /	IgG trough: mg/dL	Date: / /
Diabetic: ◯ Y ◯ N	Comorbidities:		Allergies: ◯ NKDA ◯ Other:			
Has patient received immune globulin previously? ◯ Y ◯ N	If yes, product information:			Date of last infusion: / /	Date of next infusion: / /	
TREATMENT ARRANGEMENTS:	Ship Meds: ◯ Home ◯ Doctor's Office	Start Date: / /	*Counseling and education provided by Meijer's Clinical Team			

Prescription Information

Medication/Products

◯ Bivigam® 10% ◯ Carimune® NF ◯ Flebogamma® 5% ◯ Flebogamma® 10% ◯ GammaKed® 10% ◯ Gammagard® Liquid10%

◯ Gammaplex® 5% ◯ Gammagard® S/D ◯ Gamunex-C® 10% ◯ Octagam® 5% ◯ Octagam® 10% ◯ Privigen® 10% ◯ IVIG (pharmacy to determine)

Therapy Regimen

Dose: _____ g/kg | Total Dose: _____ grams | Daily for: _____ days, every _____ weeks

#Doses: | Refills: | ***Administration Rate:*** _____ ◯ ***Per manufacture guidelines, as tolerated:*** ◯

Pre-Medications and Pre-Protocol

◯ Diphenhydramine _____ mg 30 min before infustion ◯ PO ◯ IVP
◯ Acetaminophen _____ mg 30 min before infustion PO
◯ Other:
◯ Other:

◯ Hydration Infuse _____ mL _____ solution
◯ Prior to ◯ During ◯ Following
◯ Solu-Cortef® _____ mg slow IVP
◯ Solu-Medrol® _____ mg slow IVP
◯ Pre ◯ Halfway ◯ Upon Completion

Flushing Protocol

◯ Sodium Chloride 0.9% 5-10 mL pre and post medications

◯ Heparin _____Units/mL _____mL as needed

Anaphylaxis Orders and Medications

Orders:
1. Stop infusion
2. Call 911 and prescribing physician
3. Administer medications below as per protocol

◯ **Diphenhydramine**
Administer 25-50 mg slow IV/IM
Dispense: 1 x 50 mg vial

◯ **Epinephrine**
◯ Administer 0.3 mg (1:1000) Sub-Q (≥ 30 Kg)
◯ Administer 0.15 mg (1:2000) Sub-Q (< 30 Kg)
Dispense: 1 x 50 mg vial

◯ **Sodium Chloride 0.9%**
Use as directed per the protocol
Dispense: 1 x 500 mL Bag

Ancillary Supplies

◯ As needed for proper administration and disposal of medication

Skilled Nursing Visits

◯ As needed for IV access, administration and proper clinical monitoring

Administration procedures to be followed per pharmacy protocol.
Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature:	Date

Substitution Permitted

Physician Signature:	Date

Dispense as Written