



## PRESCRIPTION and INFUSION ORDER

### Intravenous Immunoglobulin (IVIg)



**Order Date:**\*

**Preferred Location:**

**Patient Name:**\*

First Name

Middle Initial

Last Name

Suffix

**Date of Birth:**\*

**Preferred Language:**

**Phone:**\*

**Known As:**

**Address:**\*

Address Line 1

Address Line 2

City

State

ZIP Code

Country

## PROVIDER INFORMATION

**Practice Name:**

**Prescriber Name:**\*

**NPI Number:**\*

**Contact Name:**\*

**Contact Phone:**\*

**Contact Email:**\*

**Fax Number:**

**Address:**\*

Address Line 1

Address Line 2

City

State

ZIP Code

Country

**PATIENT'S INSURANCE**

If you have the following information, it will speed the authorization process. If not, we will obtain it from the patient.

**Primary Insurance:\***

**Member Number:\***

**Secondary Insurance:**

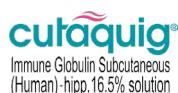
**Member Number:**

**DIAGNOSIS****Primary ICD-10 Code/Description:\***

**Secondary ICD-10 Code:**

**Description:**

**PRESCRIPTION****Select One:\***
 ASCENIV

 BIVIGAM

 CUTAQUIG

 CUVITRU

 GAMMAGARD

 GAMMAKED

 GAMUNEX-C

 HIZENTRA

 OCTAGAM

 PANZYGA

 PRIVIGEN

 NO PREFERENCE
**Patient's Weight:\***

 lbs       kgs
**Pre-Medication:**

- Methylprednisolone 125 mg IV
- Diphenhydramine 25 mg IV
- Diphenhydramine 50 mg IV
- Acetaminophen 500 mg PO

**Pre-Medication:**

- Methylprednisolone 100 mg IV
- Diphenhydramine 25 mg PO
- Diphenhydramine 50 mg PO
- Other:

**Initial Dose (Fill in the blank)**

(\_\_\_\_\_) mg/kg IV every (\_\_\_\_\_) weeks for (\_\_\_\_\_) doses

**Maintenance Dose:**

(\_\_\_\_\_) mg/kg IV every (\_\_\_\_\_) weeks for (\_\_\_\_\_) doses

Refills

**LAB ORDERS**

Coastal Infusion will draw labs on request. Please enter those orders below.

**Lab:**

Test Name, Timing, Frequency

**AUTHORIZATION**

My signature below certifies that the above-named individual is my patient and the therapy ordered is medically necessary. I understand that Coastal Infusion will follow industry best practices in the administration of this treatment. If I have specific additional instructions, I have entered them below.

**Additional Instructions:****Signature:<sup>\*</sup>**

Signature must match the Prescriber Name

**ATTACHMENTS****Required Attachments:**

The following specific documents are required for this drug. Please attach the following forms:

- PT Demographics (from Provider's EMR)
- Most recent clinical note

**Optional Attachments:**

Coastal Infusion can secure the following from the patient; however if this information is readily available, including it may speed the authorization process. Please check which forms are attached:

- Patient's Primary Insurance Card – Front
- Patient's Primary Insurance Card – Back
- Patient's Secondary Insurance Card – Front
- Patient's Secondary Insurance Card – Front