COASTAL INFUSION
INFUSE BETTER

PRESCRIPTION and INFUSION ORDER

Intravenous Immunoglobulin (IVIg)

SCAN FOR ONLINE FORM

Order Date:*

Preferred Location:

PATIENT INFORMATION

Patient Name:*

First Name | Middle Initial | Last Name | Suffix

Date of Birth:*

Preferred Language:

Phone:*

Known As:

Nickname

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:*

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

Clear Form

Confidential when completed. Do not send via unsecured email. Fax completed forms to (954) 361-8699.