



## PRESCRIPTION and INFUSION ORDER

### Intravenous Immunoglobulin (IVIg)



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

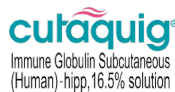
**Select One:\***



☐ ASCENIV



☐ BIVIGAM



☐ CUTAQUIG



☐ CUVITRU



☐ GAMMAGARD



☐ GAMMAKED



☐ GAMUNEX-C



☐ HIZENTRA



☐ OCTAGAM



☐ PANZYGA



☐ PRIVIGEN

**No  
Preference**  
☐ 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