



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

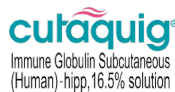
Select One:*



☐ 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