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