

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Immunoglobulin Subcutaneous Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Patient Name:	
Patient's Phone:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG Gender: Allergies: See list NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

D80.1	- Hypogammaglobulinemia
D80.2	- Select IG Deficiency
D83.	- CVID
	- Other:

REQUESTED DOCUMENTATION:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INJECTION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INJECTION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	IG levels	THERAPY:	
6			
			Continue current order until insurance approved

MEDICATION ORDERS:

NOTE: DO NOT ADMINISTER SUBCUTANEOUS IG IF PATIENT'S TEMPERATURE IS GREATER THAN OR EQUAL TO 101.5°F ORALLY AND NOTIFY MD.

MEDICATION:

- Gammagard 10%
- Gamunex 10%
- Gammaked 10%
- Hizentra 20%
- Xembify 20%
- Other: _____

DOSE:

_____ Grams **subcutaneous administration** via syringe pump to infuse per protocol

FREQUENCY:

- Every _____ days
- Every _____ weeks

DURATION:

- One time dose
- _____ weeks
- _____ months

NOTE: For HyQvia Plan of Treatment please see our website for medication specific document.

SPECIAL/LAB ORDERS:

<input checked="" type="checkbox"/>	Refills x 12 months unless noted otherwise here:
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LINE USE/CARE ORDERS:

N/A

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)

DATE:

Dispense as written/Brand medically necessary	Substitution permitted	