

Gammagard



Ph: 518-782-3899 | Fax: 518-782-3884

Date: _____

Please include the following to expedite the order

Demographics, Insurance Information, Current CBC & CMP, Last Progress Note Relevant to the Diagnosis, Current Medications, Previous Medications, IgA/IgG Levels, Written Informed Consent

PATIENT INFORMATION

PRESCRIBER INFORMATION

Patient Name: _____

Prescriber's Name: _____

Patient Contact Number: _____

NPI: _____ Date: _____

DOB: _____

Phone: _____ Fax: _____

Allergies: _____

Office Address: _____

Weight: _____ lbs kg Height: _____

Contact Person: _____

Diagnosis: _____

Contact Email: _____

ICD 10: _____

Please check this box if you **DO NOT** authorize InfusionCare to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

PREMEDS

Pre-Medications not usually indicated

No Premeds

Benadryl: PO IV 25 mg 50 mg

Acetaminophen: PO 650 mg Other: _____

Methylprednisolone: IV _____ mg

Other: _____

You authorize InfusionCare to utilize the hypersensitivity protocol established by InfusionCare.

Signature: _____

Date: _____

GAMMAGARD DOSAGE

Date of Last Treatment, if Continuation: _____

Route: Intravenous Immunoglobulin 10% (IVIG 10%)

Dose: _____ g/kg

_____ mg/kg

_____ grams (fixed dose)

Route: IV SQ

Frequency: _____

Refills: 3 months 6 months

(if not indicated order will expire 6 months from date signed)

To ensure that a Brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, InfusionCare is authorized to administer generic or biosimilar.

LAB ORDERS

No Labs

List: _____

Frequency: _____

Signature: _____

Date: _____