

Patient Information	
Patient Name: _____	DOB: _____ Phone: _____
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Date of last infusion: _____
ICD-10 code (required): _____	ICD-10 description: _____
Patient Weight: _____ lbs. Height: _____	Diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No If obese, use adjusted body wt? <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies: _____ Brand previously used: _____	

Therapy Order

<input type="checkbox"/> IV <input type="checkbox"/> SubQ Pharmacist to identify clinically appropriate brand/infusion rates. May substitute based on product availability.			
Loading Dose (as applicable)	_____	<input type="checkbox"/> mg/kg <input type="checkbox"/> gm/kg <input type="checkbox"/> grams	x _____ day(s) OR divided over _____ day(s)
			<input type="checkbox"/> One time dose <input type="checkbox"/> Other: _____ <i>*Give maintenance dose _____ weeks after loading dose*</i>
Maintenance Dose	_____	<input type="checkbox"/> mg/kg <input type="checkbox"/> gm/kg <input type="checkbox"/> grams	x _____ day(s) OR divided over _____ day(s)
			<input type="checkbox"/> Q _____ weeks x1 yr <input type="checkbox"/> Other: _____

Do not substitute. Administer brand: _____

- Infuse entire contents of Ig infusion bag/vial(s) per current dose
- If needed, round dose to nearest whole 5 gm vial for IV doses and nearest single-use vial size for subQ doses

Pre-Medication Orders: to be administered 15-30 minutes before infusion (Dispense quantity sufficient per infusion)

Acetaminophen 650mg PO Diphenhydramine 25-50mg PO
 Solu-Medrol _____ mg IVP Normal Saline 500mL IV Quzyttir 10mg IVP Cetirizine 10mg PO
 Loratadine 10mg PO Diphenhydramine 25mg IV Other: _____
 (Diphenhydramine PO will not be dispensed if IV is selected)

Flushing Protocol (Dispense quantity sufficient per protocol)	<input checked="" type="checkbox"/> Sodium Chloride 0.9% 5-10 mL per SASH protocol	<input type="checkbox"/> Heparin 3-5 mL per SASH protocol Determined by IV access: PIV (50 u/mL) OR Port/PICC (500 u/mL)
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Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
 - >30 kg (>66lbs): EpiPen® 0.3mg use as directed for anaphylaxis; may repeat in 5-10 minutes x1
 - 15-30kg (33-66lbs): EpiPen® 0.15mg use as directed for anaphylaxis; may repeat in 5-10 minutes x1
- Diphenhydramine - Administer 25-50mg orally OR IV (adult), refer to provider orders or policy for pediatric dose
- NS 500 mL IV bolus as needed (adult), refer to provider orders or policy for pediatric bolus

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

*For AmeriPharma Use Only

Drug/Brand Selection: _____ Date: _____

NP/Pharmacist Name: _____ NP/Pharmacist Signature: _____

Provider Information

Provider Name: _____ Provider's Signature: _____ Date: _____

Address, City, State, Zip: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

Opt out of AmeriPharma selecting site of care (if checked, please list site of care): _____

I authorize AmeriPharma Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. City _____ State _____

Required Documentation for Insurance Approval General Requirements

- Patient demographics
- Insurance information
- All applicable diagnoses
- History and physical
- Recent progress notes within 12 months
- Patient's height and weight
- Drug allergies
- Physician Orders

Common Variable Immunodeficiency (CVID)/ Hypogammaglobulinemia / Parkinson's Disease (PD)

- Lab last showing Ig levels and subclasses Ig levels
- Documentation of recurrent infections
- History of antibiotic usage - showing failure to respond to antibiotics
- Documented inadequate response to pneumococcal vaccine or tetanus/diphtheria

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) / Guillain-Barré Syndrome (GBS)

- Labs
- Nerve conduction study, electromyography (EMG)
- Nerve and/or muscle biopsy (if available)
- Nerve conduction velocity (NCV) test results
- Tried and failed treatments
- Spinal tap (if available)

Myasthenia Gravis

- Exacerbation
- Any history of crisis
- Thymectomy
- Any symptoms that affect respiration, speech or motor function
- Tried and failed treatments

Please fax all information to (877) 778-0399 or call (877) 778-0318 for assistance.