

Patient information	Prescriber + Shipping Information
Patient Name: _____ DOB: _____	Prescriber Name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____	NPI #: _____
1° Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate Phone: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local Pharmacy: _____ Phone: _____	Email address: _____
	If shipping to prescriber: <input type="checkbox"/> 1st Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Insurance Information (Please fax a copy of front and back of the insurance cards)

1° Insurance Plan: _____ Plan ID # _____	Policy Holder: _____ Relation: _____
2° Insurance Plan: _____ Plan ID # _____	Policy Holder: _____ Relation: _____

Clinical Information (Please fax all pertinent clinical and lab information)

ICD-10/Diagnosis Code: _____

Date of Diagnosis: _____

IgA deficiency: Yes No IgA level _____ mg/dL Date: _____

IgG trough: _____ mg/dL Date: _____ Diabetic: Yes No

Comorbidities: _____

Allergies: NKDA Other: _____

Access: Peripheral Butterfly PICC Implant Port Broviac®/Hickman®

Has patient received immune globulin previously? Yes No

If yes, product information: _____

Date of last infusion: _____ Date of next infusion: _____

Prescription

Per CoxHealth at Home protocol

PIV: 0.9% Sodium Chloride 3-20 ml before and after infusion as needed

Port : Bacteriostatic 0.9% Sodium Chloride 3-20ml into port at time of access or at least monthly, 0.9% Sodium Chloride 3-20 ml before and after infusion and as needed,

Heparin 100units/ml 5ml as lock after infusion if de-accessing

Heparin 10 units/ml 5 ml flush after infusion if remaining accessed/ maintaining line

Pre-Medication Orders:

Diphenhydramine _____ mg PO 30 minutes prior to infusion

Diphenhydramine _____ mg IV in 10ml NS 15-30 minutes prior to infusion

Acetaminophen 650mg PO 30 minutes prior to infusion

Hydration: Infuse _____ ml _____ solution IV over _____ minutes

Prior to infusion OR During infusion

Hydrocortisone _____ mg IV in 10 ml NS 15-30 minutes prior to infusion

Methylpredisolone _____ mg IV in 10 ml NS 15-30 minutes prior to infusion

Other: _____

Immune Globulin Products:

Pharmacy to determine or Other: _____

Therapy Regimen:

Dose : _____ g/kg Current weight: _____

Pharmacist will continue subsequent dosing based off of initial weight and will round dose up to the nearest vial size.

Frequency: Daily for _____ days per week every _____ weeks Other: _____

Rate: Administer per CoxHealth at Home protocol or Other: _____

Duration: Refills x 1 year or _____ infusions

Note:

Orders are initiated unless crossed out by provider

Prescriber's Signature: _____ Date: _____

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home.

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