CoxHealth at Home

Subcutaneous Immune Globulin

Phone: 1-855-419-4663

Fax: 1-417-269-0692

Patient Information

Name:_____ DOB:_____

Height: _____ ❑ in ❑ cm Weight_____ ❑ kg ❑ lbs

Address:_____

_____

City:_____ State:_____ Zip:_____

Phone:_____ Alternate:_____

SSN:_____

PLEASE INCLUDE ON FAX A COPY OF FRONT AND BACK OF INSURANCE CARD(S)

Prescriber

Prescriber name:_____

NPI: _____

Address:_____

_____

City:_____ State:_____ Zip:_____

Contact:_____

Phone:_____ Fax:_____

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

Diagnosis (ICD-10 code): _____

Allergies:_____

Subcutaneous Immune Globulin

Premedication Orders:

Please check desired premedication below. All medications will be given 30-60 minutes prior to infusion

Acetaminophen: ❑ 650mg by mouth ❑ Other:_____

Diphenhydramine: ❑ 25mg by mouth ❑50mg by mouth ❑ Other: _____

Subcutaneous Immune Globulin (Pharmacist to select product) OR write required product in blank _____

Frequency: weekly OR ❑ Other:_____

Dose: Rph will round up to the nearest combination of vial size. Subsequent dosing will be based off initial weight. RPh to use weight above at _____ g/kg

Rate: ✓ Per manufacturers guidelines OR ❑ Other:_____

Quantity to dispense: ❑ 1 year OR ❑ _____infusion(s)

Labs: every _____ (frequency) ❑ CBC with diff ❑ CMP ❑ Other:_____

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.