Hunt Regional Infusion Center
903-408-5840 (phone)
903-455-8773 (fax)

IVIG ORDER FORM

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI________

HT: _________ WT: ______KG DOB:__________________ Sex: ( ) Male ( ) Female SSN: ______________________

Street Address____________________________ City/State/Zip____________________________

Home Phone #:__________________ Work #:____________________ Cell #: ____________________

Allergies:____

INSURANCE INFORMATION

Primary Insurance Name____________________________ Policy #: ____________________

Secondary Insurance Name____________________________ Policy #: ____________________

PHYSICIAN / FACILITY INFORMATION

Physician's Name____________________ Contact Name__________________ Contact Phone # ______________

Street Address________________________________ City/State/Zip____________________________

DEA#:______________________ NPI #:__________________ Fax #: ____________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

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Date of Diagnosis: ______________

Does the patient have venous access? ○ Yes ○ No — If Yes, what type? ______________________

If No, does patient need venous access? ○ Yes ○ No — If Yes, please specify in the prescription orders.

PRESCRIPTION ORDERS

IVIG DOSE: ________________ mg/kg FREQUENCY: EVERY ____________ WEEKS

PREMEDS:____

____

POST: ____

***PHARMACY WILL CALCULATE TOTAL DOSE BASED ON IBW OR ADJUSTED BW IN OBESE PATIENTS; DOSES WILL BE ROUNDED TO THE NEAREST 5 GRAMS.**

Labs Needed: ____

"Pharmacy law may permit pharmacists to substitute a less expensive FDA-approved generically equivalent medication or biosimilar for a brand-name medication or prescribed biologic unless the practitioner indicates otherwise by writing "brand necessary" or "brand medically necessary" on the prescription."

☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT –**

UNLESS THE BOX IS CHECKED ALL PICC LINES, MIDLINES, AND CENTRAL LINES MAY BE FLUSHED WITH *HEPARIN 300unit/3mL*

Physician's Signature ____________________________ **Date:** ______________ **Time:**______________

Fax completed form to Hunt Regional Infusion Center at (903) 455-8773. PLEASE include copies of ALL patients' current insurance cards to expedite benefit verification. Also forward any lab work, Letter of Medical Necessity and any other supporting documentation supporting the use of Infusion Therapy.