TruCare PHARMACY
Phone: (844) 446-0808 | Fax: (844) 446-0809

IG (AUTOIMMUNE) PRESCRIPTION FORM

Ship To: ☐ Patient ☐ Physician

Patient Name (Required):			Physician Name:
Home Phone:	Cell Phone:		LIC#: DEA #: NPI #:
Address:			Address:
City:	State: Zip:		City: State: Zip:
Emergency Contact Name/Phone #:(Required)			Practice Name/Hospital: Specialty:
Patient Soc. Sec #:	Allergies: ☐ NKA		Physician's Phone:
DOB (Required):	Sex: ☐ M ☐ F Weight: ☐ lbs. ☐ Kg		Physician's Fax:
☐ **See attached demographic sheet**	Height: BSA:		Nurse/Key Office Contact:

INSURANCE INFORMATION | Please Complete or Attach Copies (front and back) of cards

Primary Ins:	Secondary Ins:	Rx Card (PBM):	Card Holder First Name:
City: State:	City: State:	PBM BIN:	Last Name:
Plan #:	Plan #:	City: State:	Employer:
Group #:	Group #:	Group #:	ID#:
Phone: ( )	Phone: ( )	Phone: ( )	Group #:

DIAGNOSIS INFORMATION (choose one) | Please FAX clinical notes, Labs, Tests with the prescription

☐ D69.3 Idiopathic Thrombocytopenic Purpura (ITP) ☐ G35 Multiple Sclerosis, Relapsing-Remitting Include failed therapies:_____

☐ G60.3 Polyneuropathy Idiopathic, Progessive ☐ G60.9 Idiopathic & Hereditary Peripheral Neuropathy, Unspecified ☐ G61.0 Acute Infective Polyneuritis (Guillain-Barré Syndrome)

☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy ☐ G61.9 Multifocal Motor Neuropathy ☐ G70.0 Myasthenia Gravis ☐ G71.01 Myasthenia Gravis with Acute Exacerbation

☐ G73.3 Lambert-Eaton Myasthenic Syndrome ☐ L10.0 Pemphigus Vulgaris ☐ L10.9 Unspecified Pemphigus Vulgaris ☐ L12.0 Bullous Pemphigoid ☐ L12.8 Unspecified Bullous Pemphigoid ☐ M34.0 Progressive Systemic Sclerosis ☐ M34.9 Unspecified Progressive Systemic Sclerosis ☐ M33.90 Dermatomyositis Unspecified, Organ Involvement Unspecified

☐ M33.20 Polymyositis, Organ Involvement Unspecified ☐ G25.82 Stiff-Man Syndrome ☐ M30.3 Kawasaki Syndrome ☐ Other (ICD-10 code & description) _____

Current history of: ☐ Renal Insufficiency ☐ Diabetes ☐ CHF ☐ HTN ☐ Other:_____ Does patient have a latex allergy? ☐ Yes ☐ No

Has patient previously been on IG therapy? ☐ Yes ☐ No If yes, Date: _____ Brand:_____ Dose:_____

Please Include Tests As Appropriate:

Nerve Conduction Study results, including velocities: _____ CFS studies:_____

Biopsy results: _____ Other:_____

Electromyography (EMG) results: _____

PRE-PROTOCOLS (If applicable, flush intravenous acces device per TruCare protocol)

Venous	NS	Heparin 100u/ml
Pheripheral	1-3 mL before/after use	1-3 mL before/after NS
Midline, Central (Non-Port), PICC	3-5mL before/after use, 5-10 mL after blood draw	3-5 mL before/after NS
Implanted Port	5-10mL before/after use, 10-20 mL after draw	5 mL after last NS
Groshong PICC, Midline	5-10 mL before/after use, 10-20 mL after blood draw	none

PRESCRIPTION INFORMATION (one month supply will be dispensed unless quantity is indicated)

IV Access Delivery: ☐ **Peripheral** ☐ **Central** ☐ **Other:**_____

Loading Dose: ☐ IVIG:_____grams/kilogram once daily for _____ day(s) ☐ IVIG:_____grams/kilogram course divided over _____ day(s)

Maintenance: ☐ IVIG:_____grams/kilogram once daily for _____ day(s) ☐ IVIG:_____grams/kilogram course divided over _____ day(s)

Repeat course every: _____week(s) for a total of _____course(s) or refill_____

☐ **Multiple doses will be administered on consecutive days unless ordered:** otherwise_____ consecutive **OR**_____ non-consecutive days only

Method of Delivery: ☐ Ambulatory Pump (TruCare Suggested Protocol) ☐ Pole Mount Pump ☐ Other:_____

Nursing: Administration at home by RN required: ☐ Yes ☐ No In home teach by RN: ☐ Yes ☐ No ☐ Other RN services requested:_____

Administration Rate: ☐ Per TruCare guidelines, as tolerated ☐ Per Manufacturer guidelines, as tolerated

☐ Other:_____ # of Injection sites:_____ ☐ Pharmacy to Determine # of sites:_____

PRE-MEDICATION /OTHER ORDERS

☐ **Diphenhydramine 25mg PO Dispense: #2 (25mg) - Qty per Infusion**	☐ **Acetaminophen 650mg (325mg x 2) PO Dispense: #2 (325mg) - Qty per Infusion**
☐ **Anaphylactic/EpiPen 0.3mg 2-Pak Auto-Injector Dispense: #1** - 0.3mg for patient weighing greater than or equal to 30kg. Administer IM prn severe anaphylactic reaction time one dose; may repeat one time.	☐ **Other:** _____
☐ **Supplies:** Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.	

# of Medications Prescribed: _____

Physician's Signature: _____ ☐ **DAW (Dispense as Written)** **Date:** _____