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

IG PRESCRIPTION FORM

Ship To: ☐ Patient ☐ Physician ☐ Nursing Needs ☐ Training needed

Patient Name:(Required)		Physician Name:	
Home Phone: Work Phone:		LIC#:	DEA #:
Cell Phone:		NPI #:	Specialty:
Address:		Practice Name/Hospital:	
Emergency Contact Name / Phone #:(Required)		Address:	
Patient Soc. Sec #:	Allergies: ☐ NKA	City: State: Zip:	
DOB (Required): Sex: ☐ M ☐ F	Weight: ☐ lbs. ☐ Kg	Physician's Phone:	Physician's Fax:
☐ **See attached demographic sheet**	Height: BSA: m²	Nurse/Key Office Contact:	

INSURANCE INFORMATION (Complete or Attach copies 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)

☐ Guillian-Barre Syndrome_________ ☐ CIDP & Immune neuropathies with paraproteinemia________ ☐ Immune neuropathy other than CIDP without paraproteinemia________

☐ CIDP________ ☐ Vasculitic neuropathy________ ☐ Multifocal Motor Neuropathy_______ ☐ Myasthenia gravis_______ ☐ Lambert-Eaton myasthenic syndrome________

☐ Polymyositis________ ☐ CVID_______ ☐ Dermatomyositis________ ☐ Diabetic proximal neuropathy________ ☐ Others____

Please Provide the Following Documentation: Immune Deficiency: Detailed infection history, baseline IgG levels (including subclasses), immune response to vaccinations (including report)

ITP: Platelet count:__________________________ Post-BMT or BCT:__________________________ Allogeneic:__________________________ Autologous:___________________

MEDICAL NECESSITY

Does patient already have a line ☐ Yes ☐ No If yes, type of line ____ IVIG to be infused via the existing line: ☐ Yes ☐ No

First IVIG Infusion ☐ Yes, if yes, IgA level is more than 5 mg/dl: ☐ Yes ☐ No ☐ Not Available → ☐ Ig Quantitation; IgA, IgG, IgM (prior to 1st IVIG infusion)

☐ No, if no, brand/dose of IVIG:____ Last Infusion Date: ____________________________

Note: IVIG contains IgA and is contraindicated in IgA deficient patients with antibodies against IgA and history of hypersensitivity.

Adverse reactions with previous IG treatments? ☐ Yes ☐ No If yes, which Brand of IVIG caused the reaction? ____

Is patient currently taking any other medications? ☐ Yes ☐ No List of medications ____

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

IVIG (IV IMMUNOGLOBULIN) **Route of Delivery:** ☐ **IV** ☐ **Peripheral** ☐ **Central** ☐ **Subcutaneous Injection**

MEDICATION

☐ **Bivigam** ☐ **Carimune__________%** ☐ **Flebogamma 5%** ☐ **Gammaked** ☐ **Gammaplex 5%** ☐ **Gammaplex 10%** ☐ **Gamunex 10%**

☐ **Flebogamma 10%** ☐ **Octagam 10%** ☐ **Gammagard S/D _______%** ☐ **Privigen 10%** ☐ **Octagam 5%** ☐ **Gammagard Liquid 10%**

DOSE	DIRECTIONS
_____________ grams (__________ ml) OR _____________gram(s) per kg (where clinically appropriate, round to the nearest vital size) ____________time(s) every _____________weeks	Rate protocol: Ramp up according to manufacturer's guidelines Infusion method: ☐ Gravity ☐ Pump

☐ **Other:**____ **Directions:**____

PRE-MEDICATION /OTHER ORDERS

☐ **Diphenhydramine 25-50mg PO Dispense: #2 (25mg) - 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.
☐ **Acetaminophen 650mg (325MG x 2) PO Dispense: #2 (325mg) - Qty Per Infusion**	☐ **Anaphylactic/EpiPen Jr. 0.15mg 2-Pak Auto-Injector Dispense: #1** - 0.15mg for patient weighing less than 30kg. Administer IM prn severe anaphylactic reaction times one does; may repeat one time.
☐ **Other**_____________________________________ **Qty: QS**	☐ **Lidocaine 4% applied topically to insertion site as needed**

☐ **Supplies:** Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

☐ **Quantity/Refills:** One month supply. Refill x 1 year unless noted otherwise. ☐ **Other:** ____

# of Medications Prescribed: ______________________

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

Prescriber certifies that this prescription form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Faxed prescription will only be accepted from a prescribing practioner. Prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Pursuant to OH/MO/VT law, only 1 medication is permitted per order form. Prescribers are reminded patients may choose any pharmacy of their choice.tcv101816