IMMUNE GLOBULIN PRESCRIPTION FORM

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

altScripts Specialty Pharmacy
1636 Miller Park Way, West Milwaukee, WI 53214
Phone: 414-385-9500 Fax: 414-385-7200
www.altscripts.com

Patient Information: please provide a copy of the patient's insurance card or information

Patient name:	**DOB:**	**Gender:** ☐ F ☐ M	**HT:**	**WT:**
Address:	**City:**	**State:** / **Zip Code:**	**Phone:**	
Insurance:	**Subscriber's name:**	**ID#:**	**Group #:**	

Allergies: ☐ NKDA ☐ List allergies:

Clinical Information: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization

Diagnosis / ICD-10:

Route of Administration: ☐ IVIg ☐ SCIg

First Dose of IVIg/SCIg: ☐ Yes ☐ No

Prior Ig Products Tried:

Ig indication required for administration:
- ☐ Idiopathic Thrombocytopenic Purpura
- ☐ Primary Immunodeficiency Syndrome
- ☐ Chronic Inflammatory Demyelinating Polyneuropathy
- ☐ Other (specify):

Immune Globulin Information

Immune Globulin Product (list brand name, if desired)	**Dose**	**Frequency**	**Quantity**	**Refills**

Pre-treatment Information: Nurse to administer the indicated medication(s) 30 - 60 minutes prior to Ig infusion

☐ Acetaminophen 650 mg PO ☐ Diphenhydramine 25 mg PO ☐ Diphenhydramine 50 mg PO ☐ Diphenhydramine 25 mg IV push ☐ Diphenhydramine 50 mg IV push ☐ Hydrocortisone 100 mg slow IV push
☐ Other:

Anaphylaxis Order Information

Adult (>30 kg)

☐ Epinephrine 1:1000 (0.3 mg) PRN for anaphylactic reaction

☐ Diphenhydramine 50 mg, RN to give IV or IM in case of mild allergic reaction

☐ Other:

Pediatric (15 - 30 kg)

☐ Epinephrine 1:1000 (0.15 mg) PRN for anaphylactic reaction

☐ Diphenhydramine ______ mg, usual dose 1 - 2 mg/kg (up to 50 mg) RN to give IV or IM in case of mild allergic reaction

☐ Other:

Notes / Special Instructions

Date Medication Needed:

Deliver to: ☐ Prescriber's Office ☐ Patient's Home ☐ Other:

Physician Information

Prescriber name:	**Phone:**	**Office contact name:**	
Prescriber address:	**City:**	**State:**	**Zip:**
NPI: / **DEA:**	**Fax and/or Email:**		
Prescriber signature:	**Date:**	☐ **DO NOT SUBSTITUTE**	

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