



## IMMUNOGLOBULIN (IG) IV AND SUBQ ORDER FORM

**P: 240.200.4464 F: 240.892.3005**

**PATIENT INFORMATION:** Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Patient Status:  New to Therapy  Continuing Therapy **Date of last infusion:** \_\_\_\_\_

### MEDICAL INFORMATION

**ICD-10 Code (required):** \_\_\_\_\_ **ICD-10 description:** \_\_\_\_\_  
 Patient Weight: \_\_\_\_\_ lbs./kg. (required) Height: \_\_\_\_\_ If obese, use adjusted body weight?  Yes  No Diabetic  Yes  No  
 Allergies: \_\_\_\_\_ Brand previously used: \_\_\_\_\_

### IMMUNOGLOBULIN THERAPY ORDER

IV  SubQ Active Infusions will identify clinically appropriate brand/infusion rates. May substitute based on patient's insurance and product availability.

<b>Loading Dose (as applicable)</b>	_____	<input type="checkbox"/> mg/kg <input type="checkbox"/> gm/kg <input type="checkbox"/> grams	x _____ day(s) <b>OR</b> divided over _____ day(s)	<input type="checkbox"/> One time dose <input type="checkbox"/> Other: _____ <i>*Give maintenance dose _____ days after loading dose*</i>
<b>Maintenance Dose</b>	_____	<input type="checkbox"/> mg/kg <input type="checkbox"/> gm/kg <input type="checkbox"/> grams	x _____ day(s) <b>OR</b> divided over _____ day(s)	<input type="checkbox"/> Every _____ weeks x 1 year <input type="checkbox"/> Other: _____

Do not substitute. Administer brand: \_\_\_\_\_

- Infuse entire contents of Ig infusion bag/vial(s) per current dose.
- If needed, round dose to nearest whole 5gm vial for IV doses and nearest single-use vial size for SubQ doses.

**Pre-Medication Orders: to be administered 15-30 minutes before infusion**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Acetaminophen 500mg PO       | <input type="checkbox"/> Diphenhydramine 50 mg PO / IV | <input type="checkbox"/> Cetirizine 10mg PO     |
| <input type="checkbox"/> Acetaminophen 1000mg PO      | <input type="checkbox"/> Solu-Medrol _____ mg IVP      | <input type="checkbox"/> Normal Saline 500mL IV |
| <input type="checkbox"/> Diphenhydramine 25mg PO / IV | <input type="checkbox"/> Loratadine 10mg PO            | <input type="checkbox"/> Other: _____           |

**Anaphylactic Reaction Orders:**

- Epinephrine (based on patient weight)
  - >30 kg (>66lbs.): 0.3mg IM or subQ; may repeat in 5-10 minutes x 1
  - 15-30 kg (33-66lbs.) 0.15mg IM or subQ; may repeat in 5-10 minutes x 1
- Diphenhydramine 25-50mg PO or IV as needed
- Solu-Medrol 125mg IV as needed
- NS 250-500mL IV bolus as needed

Flush orders: NS 1-20mL pre/post infusion PRN

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

### PROVIDER INFORMATION

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

ACTIVEINFUSIONS.COM

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

# ACTIVE INFUSIONS | Patient Demographics Request

## Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email [kendrick@activeinfusions.com](mailto:kendrick@activeinfusions.com). Thank you!

## PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

### Patient Name

*Last, First MI*

### Date of Birth

*MM / DD / YYYY*

### Primary Phone Number

*Best phone number*

### Alternate Phone Number

*Alternate number*

### Email Address

*Patient email address*

### Patient's Preferred Method of Contact:

Phone Call  Text Message  Email  No Preference

## EMERGENCY CONTACT

**Required for ALL patients receiving therapy for Alzheimer's Disease**

### Emergency Contact Name

*Full name*

### Relationship to Patient

*e.g. Spouse, Child, Friend*

### Emergency Contact Phone

*Phone number*

### Emergency Contact Email

*Email (if available)*

## PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

### Is the patient the Subscriber / Policy Holder?

### Subscriber / Policy Holder Name

*Full name*

Yes  No

### Relationship to Patient

*e.g. Self, Spouse, Parent*

### Subscriber Date of Birth

*MM / DD / YYYY*

### Subscriber Member ID

*Member ID*

### Insurance Company

*Insurance name*

### Group Number

*Group number*

## COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

### Program Name

*Program name*

### Program ID Number

*ID number on card*

## NOTES / ADDITIONAL INFORMATION