ABSOLUT CARE PHARMACY
10119 Broadway St.
San Antonio TX 78217
(210) 310-3060 P
(210) 310-3209 F

IMMUNOGLOBULIN ORDERS

TO BE ADMINISTERED IN ☐ HOME ☐ INFUSION CENTER

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____ PHONE: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

DIAGNOSIS: _____ ICD-10: _____

PATIENT WEIGHT: _____ LBS (REQUIRED) ALLERGIES: _____

☐ CLINICAL/PROGRESS NOTES, LABS (BMP), TESTS SUPPORTING PRIMARY DIAGNOSIS ATTACHED

LABS: REQUIRED TO BE DRAWN BY ☐ INFUSION CLINIC ☐ REFERRING PHYSICIAN

LAB ORDERS: _____

_____

IMMUNOGLOBULIN ORDERS

IG ORDERS: ☐ IV ☐ SUB Q ☐ 10% ☐ 16.5% ☐ 20% ☐ _____%

_____ GM/KG IV DIVIDED OVER _____ DAY(S)

-OR-

_____ MG/KG IV DIVIDED OVER _____ DAY(S)

FREQUENCY: EVERY _____ WEEKS FOR ONE YEAR *OR* _____ ONE TIME DOSE

PROTOCOL PRE-MEDICATION ORDERS: TYLENOL 1000MG PO, PLEASE CHOOSE ONE ANTIHISTAMINE:

☐ CETRIZINE 10MG PO ☐ DIPHENHYDRAMINE 25 MG PO ☐ LORATADINE 10MG PO

ADDITIONAL PRE-MEDICATION ORDER: ☐ SOLU-MEDROL _____ MG IVP ☐ NS 0.9 _____ ML IV

ADDITIONAL ORDERS/COMMENTS:

BRANDS AVAILABLE:

FLEBOGAMMA 5% (J1572)	FLEBOGAMMA 10% (J1572)	GAMMAGARD (J1569)	CUTAQUIG 16.5% (J3590)
HIZENTRA (J1559)	HYQVIA (J1575)	OCTAGAM 5% (J1568)	
OCTAGAM 10% (J1568)	PANZYGA (J1599)	PRIVIGEN (J1459)	

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing AbsolutCare Pharmacy and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN NAME: _____ CONTACT PERSON: _____

PHONE: _____ FAX: _____

INFUSION CENTER LOCATION

☐ 10119 Broadway St., San Antonio TX 78217