

Patient Information

First Name, Last Name: _____ Date of Birth: _____ Gender: M F

Address: _____ City, State, Zip: _____

Phone: _____ Cell _____ SSN# _____

Prescribing Physician Information

Referring Practice: _____

Practice Address: _____ City, State, Zip: _____

Prescriber Name: _____ Prescriber NPI: _____

Nurse/Key Contact: _____ Phone: _____

Fax: _____ Email: _____

Treatment Location: _____ Location Nearest Patient's Address:

Insurance Information - Please attach a copy of insurance card, front and back

Diagnosis & Clinical Information Please attach Clinical/Progress Notes, Labs, Tests, Supporting Primary Diagnosis**

ICD-10 Code	Description	ICD-10 Code	Description
<input type="checkbox"/>	Primary Immunodeficiency (PI)	<input type="checkbox"/> G70.0	Myasthenia Gravis
<input type="checkbox"/> D69.3	Idiopathic Thrombocytopenic Purpura	<input type="checkbox"/> G80.0	Hypogammaglobulinemia
<input type="checkbox"/> G61.82	Multifocal Motor Neuropathy (MMN)	<input type="checkbox"/>	Other:
<input type="checkbox"/> G61.81	Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	<input type="checkbox"/>	Other:

Pre-Medication - Not routinely needed unless the patient has had prior reactions- indicated below

Description	Description
<input type="checkbox"/> Tylenol 1000mg PO	<input type="checkbox"/> Solu-Medrol 125mg IVP
<input type="checkbox"/> Cetirizine 10mg PO	<input type="checkbox"/> Solu-Cortef 100mg IVP
<input type="checkbox"/> Diphenhydramine 25mg PO	<input type="checkbox"/> Diphenhydramine 25mg IVP
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

IVIG Orders

Description	Dosage	Frequency
<input type="checkbox"/> Asceniv (Preferred)	_____ gm per day _____ mg/kg over X _____ days	<input type="checkbox"/> One-time dose/treatment every _____ weeks
<input type="checkbox"/> Gamunex (10%)	_____ gm per day _____ mg/kg over X _____ days	<input type="checkbox"/> One-time dose/treatment every _____ weeks
<input type="checkbox"/> Gammagard (10%)	_____ gm per day _____ mg/kg over X _____ days	<input type="checkbox"/> One-time dose/treatment every _____ weeks
<input type="checkbox"/> Privigen (10%)	_____ gm per day _____ mg/kg over X _____ days	<input type="checkbox"/> One-time dose/treatment every _____ weeks
<input type="checkbox"/> Octagram (10%)	_____ gm per day _____ mg/kg over X _____ days	<input type="checkbox"/> One-time dose/treatment every _____ weeks
Patient Weight: _____ lbs. _____ kg		

Infuse One will select the product based on payor requirements, product availability, and indication.

Notes: _____

I authorize Infuse One and its clinical representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Infuse One.

Provider Phone Line:
 833-881-6048

- Please be sure to attach all of the following:
- Patient demographics
 - Patient medical insurance card copied front and back
 - Patient pharmacy card copied front and back (if they have one)
 - Most recent chart notes, diagnostic testings, and labs.
 - Proof of patient being concurrently treated with any other biologics

Physician Signature: _____
 Date: _____