

Deliver to: Patient's Home Prescriber's Office Other: _____ Hold shipment until notified by prescriber Anticipated Start Date: _____

1. Patient Information

Last Name: _____ Home Phone: _____ Work/Mobile Phone: _____
 First Name: _____ Home Address: _____
 S.S. #: _____ Date of Birth: _____ City: _____ State: _____ Zip: _____
 Guardian/Caregiver: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance: _____ Phone: _____ Prescription Card: _____ Phone: _____
 Subscriber Name: _____ Policy #: _____ BIN/PCN: _____
 Policy #: _____ Group #: _____ Medicare #: _____ Medicaid #: _____

3. Prescriber Information

Prescriber Name: _____ MD DO NP PA License #: _____ NPI #: _____ DEA #: _____
 Practice Name: _____ Phone: _____ Fax: _____
 Address: _____ Office Contact: _____ Phone: _____
 City: _____ State: _____ Zip: _____ Collaborating Physician: _____

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Medical History: Renal insufficiency Thromboembolic event CHF Diabetes HTN Other: _____
 Patient received IVIG previously? Yes No Neurological studies: _____
 Allergies: _____
 Plt count/Date: _____

D69.3 Immune Thrombocytopenic Purpura G61.0 Guillain-Barre Syndrome G70.01 Myasthenia Gravis with (acute) exacerbation
 G25.82 Stiff-man Syndrome G61.81 Chronic Inflammatory Demyelinating Polyneuritis L10.0 Pemphigus Vulgaris
 G35 Multiple Sclerosis G62.89 Multifocal Motor Neuropathy M33.20 Polymyositis, organ involvement unspecified
 G60.3 Idiopathic Progressive Neuropathy G70.00 Myasthenia Gravis without (acute) exacerbation M33.90 Dermatopolymyositis, organ involvement unspecified
 Other: _____

5. Prescription Information

Medication Orders	Brand	Therapy Regimen	Refills
<input type="checkbox"/> IVIG <input type="checkbox"/> SCIG		Dose: _____ g/day x _____ days, every _____ weeks	
<input type="checkbox"/> IVIG <input type="checkbox"/> SCIG		Dose: _____ g/kg/day x _____ days, every _____ weeks	
Pre-Meds: <input type="checkbox"/> Tylenol® 500-1000 mg PO PRN <input type="checkbox"/> Benadryl® 25-50 mg PO PRN <input type="checkbox"/> IV Steroids: _____ <input type="checkbox"/> IV Hydration: _____ <input type="checkbox"/> Other: _____		<input type="checkbox"/> Anaphylaxis Kit: • Epinephrine IM/SC 1:1000-0.3mg UD PRN anaphylaxis reaction • Epinephrine injection, USP auto-injector IM/SC UD PRN anaphylaxis reaction • Diphenhydramine IV 50mg/ml UD PRN anaphylaxis reaction • NS IV 500ml UD PRN anaphylaxis reaction. <input type="checkbox"/> Include 0.9 NaCl, Heparin 10-100 units/ml, and/or D5W flushes PRN to establish and maintain IV access <input type="checkbox"/> Ramp infusion as directed by manufacturer as tolerated by patient <input type="checkbox"/> Provide nurse for infusion of medication(s) ordered	

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature _____ Date ____ / ____ / ____

Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible _____ **PREScriBER SIGNATURE REQUIRED. NO STAMPS.** Date ____ / ____ / ____

Prescriber Signature-Dispense as Written _____ **PREScriBER SIGNATURE REQUIRED. NO STAMPS.** Date ____ / ____ / ____