



Ship To:  In Office  Infusion Suite  At Home  Other \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name:	SSN:	DOB:	
Address:	City:	State:	Zip:
Home Phone:	Height:	Weight:	Gender: Male Female
Cell Phone:	Email Address:		

**INSURANCE INFORMATION (or attach copy of cards)**

Primary Insurance Co:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

**CLINICAL INFORMATION (Fax all pertinent clinical and lab information)**

Diagnosis (ICD-10): \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Common Variable Immune Deficiency (CVID) Other CVID (Part B) D83.9 or D83.8	Combined Immune Deficiency 81.9	Severe Combined Immune Deficiency D81.1, D81.2	Hypogammaglobulinemia D80.1
Other Combined Immune Deficiencies D81.89	Immune-mediated Thrombocytopenia Purpura (ITP) D69.3	Kawasaki Disease M30.3	Wiskott-Aldrich Syndrome D82.0

Has patient received immune globulin previously?  No  Yes: Date of last infusion \_\_\_\_\_ Date of next infusion: \_\_\_\_\_

Comorbidities: \_\_\_\_\_

ALLERGIES:  NKDA  Other \_\_\_\_\_

**PRESCRIPTION INFORMATION (or attach a copy of the prescription)**

**Subcutaneous IG Therapy:**

Preferred brand \_\_\_\_\_ OR  Pharmacist will determine appropriate product based on clinical assessment, insurance requirements and availability

Refills: \_\_\_\_\_ times (as allowed by state or payer requirements)

**Directions:**

Administration Rate = Follow Manufacturer's Guidelines  Administer \_\_\_\_\_ mg per kg (+ or - 10%)  Administer \_\_\_\_\_ gm every \_\_\_\_\_ days

**Other Medication**

Acetaminophen 650 mg tablet  Premedication:30 min before infusion PO  Post infusion every 4-6 hours as needed for fever/headache.

Diphenhydramine 25 mg capsule  Premedication:30 min before infusion PO  Post infusion every 4-6 hours as needed for itching/site reactions.

Lidocaine 2.5% and Prilocaine 2.5% cream 30 g. Apply small amount topically to insertion site(s) prior to needle insertion as needed.

Other \_\_\_\_\_ Strength: \_\_\_\_\_ Directions: \_\_\_\_\_

Other \_\_\_\_\_ Strength: \_\_\_\_\_ Directions: \_\_\_\_\_

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.  Dispense as written

**NURSING**

Nursing Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Skilled Nursing Visits for Immune Globulin SubQ administration and education of patient and/or caregiver to perform therapy independently when necessary. To provide education related to disease process and IG therapy. To provide an assessment of patient's general overall health status. To provide skilled nursing visits PRN for additional education and support.

**PHYSICIAN INFORMATION**

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:		
NPI #:	Tax ID #	
Prescriber Signature:	Date	

Your signature authorizes BioPlus Specialty Pharmacy Services,LLC, and their network of pharmacies, MedScripts Medical Pharmacy, River Medical Pharmacy, Route 300 Pharmacy, and Santa Barbara Specialty Pharmacy (the "BioPlus Pharmacies"), to act on your behalf to obtain prior authorization, including appeals and peer to peer reviews, for the prescribed medications. We will also pursue available copy and financial assistance on behalf of your patients.  
 BioPlus Specialty Pharmacy 376 Northlake Blvd., Altamonte Springs, FL 32701 BioPlus Specialty Pharmacy 100 Southcenter Ct., Suite 100, Morrisville, NC 27560 BioPlus Specialty Pharmacy 13925 Yale Ave., Suite 145, Irvine, CA 92620  
 MedScripts Medical Pharmacy 1325 Miller Rd., Suite K, Greenville, SC 29607 River Medical Pharmacy 4752 Research Drive, San Antonio, TX 78240 Route 300 Pharmacy 1206 Route 300, Suite 103, Newburgh, NY 12550  
 Santa Barbara Specialty Pharmacy 4690 Carpinteria Ave, Ste B, Carpinteria, CA 93013

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**Sales Person:**