



# Patient Referral/Medication Request – IVIG Therapy

**Aetna Specialty Pharmacy®**  
 503 Sunport Lane  
 Orlando, FL 32809  
**Phone:** 1-866-782-2779 (1-866-782-ASRX)  
**FAX:** 1-866-329-2779 (1-866-FAX-ASRX)

Today's Date: \_\_\_\_\_ Anticipated Start Date: \_\_\_\_\_

**PATIENT INFORMATION**

First Name:		Last Name:	
Address:		City:	State: Zip:
Home Phone:		Work Phone:	Cell Phone:
DOB:	Height:	Weight:	Allergies:
Ship Meds to: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Doctor's Office		Access Type:	

**INSURANCE INFORMATION**

<b>Primary Insurance:</b>		<b>Pharmacy Benefit Manager (PBM):</b>	
Policy #:	Group #:	Insured:	Phone:
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:

**Secondary Insurance:**

Policy #:	Group #:	Insured:	Phone:
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**PHYSICIAN INFORMATION**

First Name:		Last Name:		M.D./D.O.	
Address:		City:	State:	Zip:	
Phone:	Fax:	St Lic. #:	NPI #:	DEA #:	UPIN:

Office Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**DIAGNOSIS:**

<b>Primary:</b>	ICD 9:	<b>Secondary:</b>	ICD 9:
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**PRESCRIPTION (Please select from below and provide approximate days supply.)**

**IVIG ORDERS: Patient's Current Weight: \_\_\_\_\_ lbs/kg (required)**

<p><b>Gamunex 10 %</b> _____ mg/kg or _____ Grams Q _____          (Available: Gamunex)          (Gammagard/Gamunex only) Incompatible with NS # of Refills _____  <b>(1, 2.5, 5, 10, 20 gram vials available)</b></p> <p><input type="checkbox"/> NS Flush: _____ ml Q _____ and PRN</p> <p><input type="checkbox"/> Heparin Flush 100 U/ml _____ ml Q _____ and PRN          (Only for Central/PICC Lines)</p> <p><input type="checkbox"/> Heparin Flush 10 U/ml _____ ml Q _____ and PRN          (Only for Peripheral Lines when infusion is consecutive days)</p> <p><input type="checkbox"/> D5W 50 ml – Infuse _____ ml Pre _____ ml Post infusion</p> <p><input type="checkbox"/> Epinephrine _____ <input type="checkbox"/> Benadryl _____ mg</p>	<p><b>Carimune</b> _____% _____ mg/kg or _____ Grams Q _____  <b>(6 gram and 12 gram vials available at Aetna Specialty Pharmacy)</b> # of Refills _____</p> <p><input type="checkbox"/> Sterile Water _____ ml per 6 gram vial</p> <p><input type="checkbox"/> Sterile Water _____ ml per 12 gram vial</p> <table border="1"> <thead> <tr> <th>Target Concentration</th> <th>1g vial</th> <th>3g vial</th> <th>6g vial</th> <th>12g vial</th> </tr> </thead> <tbody> <tr> <td>3%</td> <td>33.0 cc</td> <td>100 cc</td> <td>200 cc</td> <td>***</td> </tr> <tr> <td>6%</td> <td>16.5 cc</td> <td>50 cc</td> <td>100 cc</td> <td>200 cc</td> </tr> <tr> <td>9%</td> <td>11.0 cc</td> <td>33 cc</td> <td>66 cc</td> <td>132 cc</td> </tr> <tr> <td>12%</td> <td>8.3 cc</td> <td>25 cc</td> <td>50 cc</td> <td>100 cc</td> </tr> </tbody> </table> <p><input type="checkbox"/> NS Flush: _____ ml Q _____ and PRN</p> <p><input type="checkbox"/> Heparin Flush 100 U/ml _____ ml Q _____ and PRN          (Only for Central/PICC Lines)</p> <p><input type="checkbox"/> Heparin Flush 10 U/ml _____ ml Q _____ and PRN          (Only for Peripheral Lines when infusion is consecutive days)</p> <p><input type="checkbox"/> Epinephrine _____ <input type="checkbox"/> Benadryl _____ mg</p>	Target Concentration	1g vial	3g vial	6g vial	12g vial	3%	33.0 cc	100 cc	200 cc	***	6%	16.5 cc	50 cc	100 cc	200 cc	9%	11.0 cc	33 cc	66 cc	132 cc	12%	8.3 cc	25 cc	50 cc	100 cc
Target Concentration	1g vial	3g vial	6g vial	12g vial																						
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6%	16.5 cc	50 cc	100 cc	200 cc																						
9%	11.0 cc	33 cc	66 cc	132 cc																						
12%	8.3 cc	25 cc	50 cc	100 cc																						

**Gammagard 10% \_\_\_\_\_ mg/kg or \_\_\_\_\_ Gram Q \_\_\_\_\_**  
**(Limited supply) # of Refills \_\_\_\_\_**

(Gammagard/Gamunex only) Incompatible with NS  
**(1, 2.5, 5, 10 gram vials available)**

**Gammagard SD \_\_\_\_\_ mg/kg or \_\_\_\_\_ Gram Q \_\_\_\_\_**  
**# of Refills \_\_\_\_\_**

\*\*\* Gammagard Powder: (Use must be approved by Baxter at request of MD) \*\*\*

<p><input type="checkbox"/> NS Flush: _____ ml Q _____ and PRN</p> <p><input type="checkbox"/> Heparin Flush 100 U/ml _____ ml Q _____ and PRN          (Only for Central/PICC Lines)</p> <p><input type="checkbox"/> Heparin Flush 10 U/ml _____ ml Q _____ and PRN          (Only for Peripheral Lines when infusion is consecutive days)</p> <p><input type="checkbox"/> D5W 50 ml – Infuse _____ ml Pre _____ ml Post infusion</p> <p><input type="checkbox"/> Epinephrine _____ <input type="checkbox"/> Benadryl _____ mg</p>	<p><b>Octagam 5 % _____ mg / Kg or _____ Gram Q _____</b>  <b>(1, 2.5, 5, 10 gram vials available) # of Refills _____</b></p> <p><input type="checkbox"/> NS Flush: _____ ml Q _____ and PRN</p> <p><input type="checkbox"/> Heparin Flush 100 U/ml _____ ml Q _____ and PRN          (Only for Central/PICC Lines)</p> <p><input type="checkbox"/> Heparin Flush 10 U/ml _____ ml Q _____ and PRN          (Only for Peripheral Lines when infusion is consecutive days)</p> <p><input type="checkbox"/> Epinephrine _____ <input type="checkbox"/> Benadryl _____ mg</p> <p><b>Other Drug:</b> _____ dose _____ or mg / KG          Frequency _____ Route _____ # of Refills _____</p> <p><input type="checkbox"/> NS Flush: _____ ml Q _____ and PRN</p> <p><input type="checkbox"/> Heparin Flush 100 U/ml _____ ml Q _____ and PRN          (Only for Central/PICC Lines)</p> <p><input type="checkbox"/> Heparin Flush 10 U/ml _____ ml Q _____ and PRN          (Only for Peripheral Lines when infusion is consecutive days)</p> <p><input type="checkbox"/> Epinephrine _____ <input type="checkbox"/> Benadryl _____ mg</p>
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**Prescriber's Signature Required by Law:**

**Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space.  
 Incomplete information may result in therapy delay. Please complete all fields.**