BioPlus® Infusion | Santa Barbara Pharmacy

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SCIG

Fax: 866-523-5406
Phone: 800-829-3975
bioplusinfusion.com

Ship To: ☐ In Office ☐ Infusion Suite ☐ At Home ☐ Other_____

PATIENT INFORMATION

Name:		SSN:		DOB:
Address:		City:	State:	ZIP:
Home Phone:	Cell:	Height:	Weight:	Gender: ○ Female ○ Male
Email:		Allergies:		

INSURANCE INFORMATION (or attach copy of cards)

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

CLINICAL INFORMATION

Diagnosis (ICD-10): _____ **Date of Diagnosis:** _____

Common Variable Immune Deficiency (CVID) Other CVID (Part B) D83.9 or D83.8 Combined Immune Deficiency D81.9 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 Wiskcott-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 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 _____ grams 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: _____

Anaphylaxis Kit Order (Infusion Reaction Management x 1/year)

☐ Epinephrine ☐ IM ☐ SUBQ Qty: _____ Refills: _____

Adult 1:1000, 0.3 mL (>30 kg/>66lbs) PRN severe allergic reaction, call 911. May repeat in 5-15 minutes as needed.

NURSING

☐ **Nursing Agency:** _____ **Phone:** _____

Skilled Nursing Visits for infliximab intravenous administration and education. To provide education related to the disease process and therapy.
To provide an assessment of patient's general overall health status. To provide skilled nursing visits PRN for additional education and support.

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

PHYSICIAN INFORMATION

INFUSION TYPE: ☐ At Home ☐ In Office

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