EVENTUS RX

QUICKER ACCESS, BETTER OUTCOMES

Fort Myers, FL Phone: 866-249-2696 Fax: 866-330-7487
E-Prescribe: NPI # 1770090482 Visit Us Online: eventusrx.com

IG Order Form

DATE: _____ NEEDS BY DATE: _____
SHIP TO: ☐ OFFICE

Patient Information

Patient Name

Address

City, State, Zip

Main Phone Alternate Phone

Social Security #

Date of Birth ☐ Male ☐ Female

Provider Information

Prescriber Name

DEA # NPI # License #

Address

City, State, Zip

Phone Fax

Contact Person

Clinical Information

Diagnosis:

☐ D80.0 (congenital Hypogammaglobulinemia)
☐ D80.1 (Nonfamilial hypogammaglobulinemia)
☐ D80.6 (Selective Antibody Deficiency)
☐ D81.9 (SCID)
☐ D83.9 (CVID)
☐ G35 (Multiple Sclerosis)
☐ G61.0 (Guillane-Barre Syndrome)
☐ G61.81 (CIDP)
☐ G70.00 (MG)
☐ Other: Dx code _____ Condition _____ Comorbidities _____

Drug Allergies: _____

_____

Lab results:

☐ IgA level _____ Date _____ IgA deficiency? _____ IgG trough _____
Date _____ Diabetic? _____
☐ Access: ____ Peripheral ____ PICC ____ Port
☐ Has patient received previous IG therapy? _____
Date of last infusion if known: _____

Prescription Information

Eventus Clinical Pharmacist to recommend proper dose, route and frequency: ☐ YES ☐ NO

OR

SQIG Orders: _____ grams SQIG to be infused as directed once weekly (recommended method by manufacturer)
Refills x _____ months

OR

List Product if specific product requested: _____
IVIG Orders
_____ mg/kg/day _____ days every month for _____ months
OR
_____ grams per day _____ days every month for _____ months
OR
Other: _____
List Product if specific product requested: _____
Either product to be infused per manufacturer guidelines unless specific orders given
Specific orders: _____
_____

Pre Meds: (check all that apply)
☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg IVP or PO
☐ Hydrocortisone 100mg IVP
☐ Other _____
☐ Epinephrine 1: 1000 and diphenhydramine 50mg to be given per protocol for anaphylaxis

Post Meds:

_____
_____
_____
_____

PLEASE FAX COPY OF : 1) PRESCRIPTION CARD FRONT & BACK 2) CLINICAL NOTES 3) MEDICAL CARD FRONT & BACK

_____ _____
Prescriber's Signature (no stamps) Date