Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

Immune Globulin Form

Chartwell Specialty Pharmacy
Phone: 1-800-366-6020 | Fax: 412-920-1869

Date:

PATIENT INFORMATION

Patient Name:		DOB:	Gender: ☐ Male ☐ Female
Phone:	Cell:	SSN:	
Address:		Email:	
City:	State: / Zip:	Emergency Contact:	
Primary Insurance:		Phone:	Relationship:
		Secondary Insurance:	
Insured:		Insured:	
Policy #:	Group #:	Policy #:	Group #:
Primary Diagnosis:	ICD 10:	Secondary Diagnosis:	ICD 10:
Height:	Weight:	Allergies:	

PRESCRIPTION ORDERS: Medication infused per PI recommended rate and via rate-controlled device per therapy

☐ Cuvitru 20% ☐ Gammagard Liquid 10% ☐ Gammagard S/D ☐ Gamunex-C 10% ☐ Hizentra 20% ☐ HyQvia 10%
☐ Privigen 10% ☐ Xembify 20% ☐ Other:

Directions: ☐ Infuse IV ☐ Infuse SC ☐ Continuation of therapy

Initial Dose: _____ grams divided over _____ days; OR

Ongoing Dose: _____ grams divided over _____ days; OR

Quantity/Refills: 1-month supply; refill x 12 months unless otherwise noted:

Premedications 30 minutes before start of IG: Patient may refuse ☐ No premedications indicated

☐ Acetaminophen PO ☐ 325mg ☐ 650mg ☐ Diphenhydramine PO ☐ 25mg ☐ 50mg

☐ Hydration, solution: _____ Volume: _____ mL/hr: _____ Other:

NURSING & OTHER ORDERS

☐ Administer IVIG or teach SCIG self administration, via pump ☐ Patient able to self administer (SCIG ONLY)

☐ Initiate access device (insert peripheral IV, SC needles, access implanted port or use existing PICC)

☐ Flush IV access according to Chartwell protocol

☐ Anaphylaxis kit per Chartwell protocol x 1 year	☐ EpiPen to be provided by patient's preferred pharmacy
☐ Obtain Labs:	☐ Lab Frequency:

PHYSICIAN INFORMATION

Name:	Practice:		
NPI:	Contact:		
Phone:	Fax:		
Address:	City:	State:	Zip:

By signing, I certify/recertify that the above therapy products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Physician Signature:	Date: