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To: River's Edg	ge Pharmacy		From(Of	fice Contact) :		
Fax: 877.834.1231 E-Fax: faxes@repharmacy.com			Fax:			
Phone: 866.4	13.3156		r none			
Urgent	For Review	Please Cor	mment	Please Reply	Please Recycl	
	PROCESSING OF		T'S PRESC	CRIPTIONS, THE FO	OLLOWING	
Rx (presc	ription signed and	dated by preso	criber)			
Insurance	e Information (incl	ude copy of in	surance ca	ard if available)		
Datient Γ	Demographics (inc	lude natient's l	neight and	l weight)		
		·		,		
Recent C	linical Notes (histo	ory and physica	al, most re	cent progress notes)		
Diagnosi	s Documentation	(i.e. labs, diagn	ostic studi	es, biopsy, etc.)		
ADDITIONAL	. INCLUDED DOC	UMENTATIO	N (BY DIS	SEASE STATE):		
Primary I antibody	_	/ (labs/lg levels	s, tried and	failed medications, p	oneumococcal	
CIDP/GBS medication	•	e conduction s	study, luml	oar puncture, labs, tr	ied and failed	
•	ogic testing, tried a tions or MG crisis)	ınd failed med	ications, a	ny notes that describ	е	
				l failed medications) psy, tried and failed n	nedications)	
Comme	 ents:					

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AUTOIMMUNE PRESCRIPTION FORM

Number of Drugs Prescribed:

Phone: 866.413.3156 Fax: 877.834.1231/faxes@repharmacy.com



Patient Inform	nation							
Name:			Parent/Guardian (if applicable):					
DOB:	Height:		Weight:	Phone:		Email:		
Address:	I			City, State, Zip:				
Male Female First Dose of IVIG: Y			IVIG: YES NO	Prior IG Brands Used:				
Specific Adverse Re	action w/ Prior Bra	ands:						
Allergies:								
Diagnosis								
•	cephalopathy G04	ł.81	Multifocal I	Motor Neuropathy G61.82	Polym	nyositis M33.20		
		Polyneuropathy (CID	P) G61.81 Myastheni	a Gravis (MG) G70.0	Pediat	Pediatric Autoimmune Neuropsychiatric Disorders		
Dermatopolym	yositis M33.90	, , , , , ,	, Myasthenia	Gravis w/Acute Exacerbation G7	0.01 Associ	ated with Streptococca	l Infections (PANDAS) D89.89	
Guillain- Barre S	yndrome (GBS) <mark>G6</mark>	51.0	Pemphigoi			erson Syndrome G25		
Inflammatory N	Neuropathies G61	.89	Pemphigus	L10.9	Other	:		
Prescription In	formation							
Product: Pharma	acist to Determine	Physician Bra	nded					
	mmunoglobulin		//	☐ Subcutaneous Im	_			
Infuse:	e 1gm/kg – 2gm/k	kg infuse:	gm/kg	Infuse:	e # of sites unless	unless alt # of sites indicated here:		
IV daily over _		days;			times;	weeks;	months	
	repeat every	weeks; _	montl	ns				
Other:				Otner:				
Infusion Rate: Plea	ase select one and	d provide complete	information					
Pharmacist to de	etermine per manu	ıfacturer recommend	dations					
Start at	mL/hour then ir	ncrease by	mL/hour every	minutes to maximum r	ate	_mL/hour		
IV Access:	Peripheral	PICC Po	rt Other:					
IV Maintenance /F	luching). Dianone	a avantitu sufficia	-4					
		se quantity sufficie illed syringe: flush IV		ium chloride 1-10mL to maint	ain line natency			
	· ·	· -		eeded to maintain line patency				
Pretreatment: Disp	oense quantity su	ıfficient						
	-	•	15-30 minutes before e outh 15-30 minutes befor					
	= :							
Otner:								
Ancillary Supplies:	Dispense ancillar	v supplies and equi	nment needed to provid	e home infusion therapy		Refills:		
		ends/holidays. Not		e nome injusion areapy		110111101		
Labs to be drawn:	oc arawn on week	enas, nonauys. 1400	JOI STATIOUS.	Frequency of labs:				
	ctic Reactions: Ar	naphylaxis kit to be	used in the event of ar	naphylactic reaction and incl	udes the below	components:		
				ty 1), Epinephrine injection a LOmL prefilled syringe (qty 4)	uto-injector 0.3r	ng (>30kg pt) or 0.15	img (<30kg pt) (qty 1	
Nursing Orders: Nu independent with		· IVIG and ancillary	medications per orders.	Skilled nursing visits for educ	cation of SCIG ad	lministration (not ap	oplicable if	
Physician Info	rmation							
Physician:				Office Contact:				
Address:				City, State, Zip:				
Phone:	F	ax:		License:		NPI:		

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(Prescription is void if number of drugs are not indicated. Regulation 16 CCR 1717.3)

Prescriber's Signature:	Date:

IMMUNE DEFICIENCY PRESCRIPTION FORM

Phone: 866.413.3156 Fax: 877.834.1231/ faxes@repharmacy.com



Patient Information	1					
Name:			Parent/Guardian (if applicable):			
DOB:	Height:		Weight:		Phone:	Email:
Address:	Address:			City, State, Zip:		
Male Female First Dose of IVIG: YES NO			NO	Prior IG Brands Used:		
Specific Adverse Reaction w	// Prior Brands:					
Allergies:						
Diagnosis						
Combined Immunodefic Common Variable Immu CVID w/Predominant Im Prescription Inform	inodeficiency, Unspirency Transpirency	oecified D83 -Cell Disord	3.9 I ers D83.1 N	mmunode	Hypogammaglobulinemia D80.0 ficiency w/Increased IgM D80.5 Hypogammaglobulinemia D80.1	Other Combined Immunodeficiencies D81.89 Other:
Product: Pharmacist to D		ysician Bra	naea:		☐ Subcutaneous Immunoglobulir	
☐ Intravenous Immunoglobulin Recommended dose 0.4 − 0.8 gm/kg infuse:gm/kg Infuse: IV daily overdays;				Pharmacy to determine # of sites unless alt # of sites indicated here: Infuse: grams subcutaneously;		
repeat every						weeks; months
Other:					Other:	
Infusion Rate: Please select Pharmacist to determine						
Start at mL/h	our then increase by	/	mL/hour ever	У	minutes to maximum rate	mL/hour
IV Access: Peripher	al PICC	Ро	rt Other: _			
	OmL prefilled syrinnL prefilled syringe: uantity sufficient tablet: 1-2 tablets g capsule: 1-2 caps	nge: flush IV flush with : s by mouth ules by mo	/ access device with 100 units/mL 3-5 ml 15-30 minutes bef uth 15-30 minutes	L as needed fore each i before eac	ch infusion	су
Ancillary Supplies: Dispens	e ancillary supplie.	s and equip	oment needed to p	rovide hoi	me infusion therapy	Refills:
Labs: Labs will not be drawn Labs to be drawn:	n on weekends/ho	lidays. Not	for STAT labs.		Frequency of labs:	
	psule (qty 2), Diph	enhydrami	ne 50mg/mL 1mL v	vial (qty 1)		ow components: 0.3mg (>30kg pt) or 0.15mg (<30kg pt) (qty 1
Nursing Orders: Nurse to a independent with therapy)		d ancillary	medications per or	rders. Skill	ed nursing visits for education of SCIG	administration (not applicable if
Physician Informati	on					
Physician:				Of	fice Contact:	
Address:				Cit	y, State, Zip:	
Phone:	Fax:			Lic	ense:	NPI:
Number of Drugs Prescribe	d:		(Prescription is v	void if num	ber of drugs are not indicated. Regula	tion 16 CCR 1717.3)

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Prescriber's Signature:	Date: