FAST
Fast Access Specialty Therapeutics
Powered by: FACTOR ONE SOURCE PHARMACY

FAX 1-844-504-3278
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www.FOSRX.com

IMMUNE DEFICIENCY FORM

PATIENT INFORMATION:

Patient Name:_____
Date of Birth:_____Male: ☐ Female: ☐
Address:_____
City/State/Zip:_____
Tel:_____Alt Tel:_____
SS#:_____Wt:_____Ht:_____
NKDA: ☐ Allergy:_____
Emergency Contact:_____

INSURANCE INFORMATION:

Primary Pharmacy Insurance_____
Member Name:_____
Member ID:_____
Rx Group #:_____
BIN#_____PCN#_____
Customer Service #:_____

Please attach a copy of the front and back of the patient's insurance card, if available.**

DIAGNOSIS AND CLINICAL INFORMATION:

Diagnosis : ☐ G61.81 CIDP ☐ G70.01 MYASTHENIA GRAVIS ☐ M33.90 Dermatomyositis ☐ D80.0 Congential Hypogam
☐ Other:_____
Adverse reaction with previous IG treatment? ☐ Yes ☐ No If Yes, what brand of IG caused the reaction:_____
Venous Access: ☐ Peripheral IV ☐ Port-a-Cath ☐ PICC ☐ Central Line ☐ Other:_____
Weight:_____ kg Date:_____ Height:_____ in Date:_____

PRESCRIBER INFORMATION:

Prescriber Name:_____Specialty:_____ Date:_____
Address:_____City/State/Zip:_____
Contact Name:_____Phone #:_____Fax #:_____
NPI#:_____DEA #:_____UPIN #:_____
By signing this form and using our services, you are authorizing F.A.S.T. to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.
Prescriber Signature Below: (*Physician attests this is his/her legal signature.* **NO STAMPS**)

_____ _____
Substitution Allowed *Dispense as Written*

PRESCRIPTION:

MEDICATION	DOSE	DIRECTIONS
☐ Bivigam ☐ Carimune ☐ Flebogamma 5% ☐ Gammagard S/D ☐ Gammagard Liquid 10% ☐ Gammaked ☐ Gammaplex ☐ Gamunex 10% ☐ Octagam 5% ☐ Octagam 10% ☐ Privigen 10% ☐ Other:_____	Infuse_____ grams ***OR*** Infuse _____grams/kg (where clinically appropriate, round the nearest vial size) _____ time(s) every _____weeks	☐ Rate Protocol: Ramp up according to manufacturer's guidelines or specify rate _____ Infusion method: ☐ Flow Regulator ☐ Pump

Quantity/Refills: Dispense 1 month supply. Refill X 1 year unless noted otherwise
☐ Other:_____

Premedication to be given 30 minutes prior to infusion:
☐ Diphenhydramine 25mg – 50mg by mouth (contraindicated in patients with Myasthenia Gravis)
☐ Acetaminophen 325mg – 650mg by mouth
☐ Lidocaine 4% applied topically to insertion site as needed
☐ Other:_____

Flushing Orders:
☐ Normal Saline – 1 - 50ml IV before and after infusion
☐ Heparin 100 units/ml 3-5ml IV as final flush for maintenance of central IV access

☐ **Nursing Orders :** MD requests IVIG in home infusion provided by FOSRX/FAST

☐ **Lab Orders:**_____

Adverse Reaction Medications: (keep on hand at all times)
☐ EpiPen® 0.3mg auto-injector 2pk, dispense #1. Dispense 0.3mg for patient weighing greater than or equal to 30kg.
Administer IM prn severe anaphylactic reaction times one dose: may repeat one time.
☐ EpiPen Jr.® 0.15mg auto-injector 2pk, dispense #1. Dispense 0.15mg for patient weighing less than 30kg.
Administer IM prn sever anaphylactic reaction times one dose: may repeat one time.
☐ Diphenhydramine 25mg – 50mg administered by mouth prn allergic reaction/anaphylaxis. (contraindicated in Myasthenia Gravis)
For patients weighing less than 35kg, the following weight-based dosing ranges will be used: Acetaminophen 10-15mg/kg, Diphenhydramine:0.5-2mg/kg