ProsperInfusion

IVIG Autoimmune Form

12637 Race Track Rd
Westchase, FL 33626
Phone/Text: (813)-749-0786
Fax: (813)-922-2457

Patient Information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male
Language: _____ Wt: _____ ☐ Kg ☐ lbs Ht: _____ ☐ cm ☐ in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email address: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Statement of Medical Necessity- Primary Diagnosis

ICD-10 Description	Code
☐ Guillain-Barre Syndrome	G61.0
☐ Chronic Inflammatory Demyelinating Polyneuritis	G61.81
☐ Multifocal Motor Meuropathy	G61.82
☐ Critical Illness Polyneuropathy	G62.81
☐ Dermatopolymyositis, Unspecified, Organ Involvement	M33.90
☐ Myasthenic Syndromes in other Diseases Classified Elsewhere	G73.3
☐ Inflammatory Polyneuropathy, Unspecified	G61.9
☐ Multiple Sclerosis	G35

ICD-10 Description	Code
☐ Myasthenia Gravis with Acute Exacerbation	G70.01
☐ Myasthenia Gravis without Acute Exacerbation	G70.00
☐ Pemphigus, Unspecified	L10.9
☐ Pemphigus Foliaceus	L10.2
☐ Pemphigus Vulgaris	L10.0
☐ Hereditary and Idiopathic Neuropathy Unspecified	G60.9
☐Polymyositis, Organ Involvement Unspecified	M33.20
☐ Stiff-Man Syndrome	G25.82
☐ Other: _____	_____

Prescription and Orders

Is this the first dose? ☐ Yes ☐ No If No, date first dose given: _____ Target Start Date: _____ Next MD Appointment: _____

Administer IVIg Product: ☐ Pharmacist to determine (or) ☐ Brand _____

Dose: (please select one and complete, pharmacy will use actual body weight unless otherwise specified)

☐ **Loading:** 2g/kg IV via gravity/pump over _____ days.

☐ **Maintenance:** _____ g/kg via gravity/pump over _____ day(s) Every _____ weeks for _____ cycle(s)

☐ **Other Regimen:** _____ g/kg per day X _____ day(s) every _____ Weeks for _____ cycle(s)

Dispense: 4 week supply

(Doses will be rounded to the nearest 5gm vial)

Refills: _____

Other Orders: _____

_____

☐ **NKDA** ☐ **Initiate Appeal Reason:** _____

Allergies: _____

Patient Records (Please Attach and Fax):

1. Insurance Card(s)and Demographic Information
2. Recent Clinical Assessment Note or H&P
3. Current Medication List
4. Diagnostics Tests

Access: ☐ **Peripheral** ☐ **PICC** ☐ **Port** ☐ **Other:** _____

Prosper Infusion Flushing Protocol is the following:

NS Flushes (10mL) #QS:
PIV: 3mL to 5mL IV pre/post + prn
PAC: 10mL IV pre/post + prn

Adult: Heparin 100 units/mL (5mL) #QS:
PIV: 3mL IV post
PAC: 5mL IV post

Pedi: Heparin 10 units/mL #QS:
PIV: 3mL IV post (3mL)

Adverse/Anaphylactic Reactions kit will contain one of each of the following per day except Epinephrine (including all supplies for administration):
Diphenhydramine 25 mg capsules and 50 mg/mL 1mL vials, 2 x Epinephrine 1:1000 (1mg/mL) ampules, NaCl 500 mL bags, SIG: U.D. PRN adverse reaction or anaphylaxis

Pre-Treatment Orders (dispense #QS per pharmacy protocol):

☐ APAP _____ 500mg or _____ 325mg PO 15-30 minutes before the infusion starts
☐ Diphenhydramine 25mg PO 15-30 min before the infusion starts
☐ Other: _____
☐ Aspirin 325mg PO 15-30 minutes before the infusion starts
☐ None

Labs:
Results will be faxed to physicians office. Labs will not be drawn on weekends or Holidays. Not approriate for STAT Labs.

☐ MD Office to Manage Labs

☐ Prosper Lab Protocol [For IV patients only):
CBC, BUN, Creatinine at day 1 of first infusion and then every 3rd Cycle

Prescriber's Signature (stamp signature not allowed) DEA Number (if required for controlled substances): _____

_____ _____ Date: _____

Write "Brand Medically Necessary" for DAW

I authorize Prosper Infusion, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization process and/or copay assistance for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Prosper Infusion, Inc

Reset Form