



Please fax completed form, insurance card, and clinical documentation to:
FAX: (843) 793-6181

OCTAGAM 10%

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Allergies: _____		
Height: _____ Weight: _____		

Indication:

D69.3 Chronic Immune Thrombocytopenic Purpura (ITP)
 M33.10 Other dermatomyositis, organ involvement unspecified
 Other _____

DOSGE ORDERS:

Chronic ITP: 2g/kg IV divided in equal doses given over 2 consecutive days every 4 weeks. Other: every _____ weeks
 Dermatomyositis: 2g/kg IV divided in equal doses given over 2-5 consecutive days every 4 weeks

PREMEDICATION ORDERS:

Acetaminophen: 1000mg PO 500mg PO 30 min prior to infusion.
 Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.
 Methylprednisolone: 62.5mg IVP 125mg IVP Other _____ 30 min prior to infusion.
 Other _____

DISCLAIMER: Referring provider attests to monitor renal function, screen for IgA deficiency, blood viscosity in patients at risk for hyper-viscosity, and hemoglobin or hematocrit prior to infusion and within approximately 36-96 hours post infusion. Referring provider attests to ensure patients blood glucose monitoring system including test strips to determine if the system is appropriate to use with maltose-containing parenteral products.

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
- Insurance card(s) – copy of front & back
- Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
- Most Recent Labs (within last 4-8 weeks) – Required:
 - CMP CBC Other: _____
 - Serum IgA level test

CAUTION: Patients with corn allergy may have hypersensitivity reaction to Octagam 10%