

Fort Myers, FL Phone: 866-249-2696 Fax: 866-330-7487 E-Prescribe: NPI # 1770090482 Visit Us Online: eventusrx.com

IG Order Form

DATE: _____ NEEDS BY DATE: ______ SHIP TO: **O** OFFICE

Patient Name Address City, State, Zip Main Phone Alternate Phone Social Security # Date of Birth	
City, State, Zip Main Phone Alternate Phone Social Security # Date of Birth □ Male □ Female Provider Information Prescriber Name DEA # NPI # License # Address	 D80.1 (Nonfamilial hypoganimaglobulinemia) D80.6 (Selective Antibody Deficiency) D81.9 (SCID) D83.9 (CVID) G35 (Multiple Sclerosis) G61.0 (Guillane-Barre Syndrome) G61.81 (CIDP)
City, State, Zip Main Phone Alternate Phone Social Security # Date of Birth □ Male □ Female Provider Information Prescriber Name DEA # NPI # License # Address	 D80.6 (Selective Antibody Deficiency) D81.9 (SCID) D83.9 (CVID) G35 (Multiple Sclerosis) G61.0 (Guillane-Barre Syndrome) G61.81 (CIDP) G70.00 (MG) Other: Dx code Condition Comorbidities
Main Phone Alternate Phone Social Security # Image: Constraint of the second s	 D81.9 (SCID) D83.9 (CVID) G35 (Multiple Sclerosis) G61.0 (Guillane-Barre Syndrome) G61.81 (CIDP) G70.00 (MG) Other: Dx code Condition Comorbidities
Social Security # Date of Birth	 D83.9 (CVID) G35 (Multiple Sclerosis) G61.0 (Guillane-Barre Syndrome) G61.81 (CIDP) G70.00 (MG) Other: Dx code Condition Comorbidities
Social Security # Date of Birth	 G35 (Multiple Sclerosis) G61.0 (Guillane-Barre Syndrome) G61.81 (CIDP) G70.00 (MG) Other: Dx code Condition Comorbidities
Date of Birth Image: Male Image: Female Provider Information Provider Information Prescriber Name Image: Ima	 G G61.0 (Guillane-Barre Syndrome) G G61.81 (CIDP) G G70.00 (MG) O Other: Dx code Condition Comorbidities
Provider Information Prescriber Name DEA # NPI # Address	 G61.81 (CIDP) G70.00 (MG) Other: Dx code Condition Comorbidities
Prescriber Name DEA # NPI # License # Address	• Other: Dx code Condition Comorbidities
Prescriber Name DEA # NPI # License # Address	
DEA # NPI # License # Address	Drug Allergies:
Address	
City State Zip	Lab results: O IgA level Date IgA deficiency? IgG trough
City, State, Lip	Date Diabetic?
Phone Fax	Access: Peripheral PICC Port O Has patient received previous IG therapy?
Contact Person	Date of last infusion if known:
	- -
Prescription	Information

Eventus Chincal Fharmacist to recommend proper dose, route and requency: TES TRO		
OR SQIG Orders:grams SQIG to be infused as directed once weekly (recommended method by manufacturer) Refills x months		
List Product if specific product requested:		
 Pre Meds: (check all that apply) Acetaminophen 650mg PO Diphenhydramine 25mg IVP or PO Hydrocortisone 100mg IVP Other Epinephrine 1: 1000 and diphenhydramine 50mg to be given per protocol for anaphylaxis 	Post Meds:	
List Product if specific product requested: IVIG Orders mg/kg/day days every month for OR grams per day days every month for Other: days every month for Other: days every month for Ust Product if specific product requested: Either product to be infused per manufacturer guidelines u Specific orders: Pre Meds: (check all that apply) Acetaminophen 650mg PO Diphenhydramine 25mg IVP or PO Hydrocortisone 100mg IVP Other Epinephrine 1: 1000 and diphenhydramine 50mg to be given per protocol for anaphylaxis	months or months months months nless specific orders given Post Meds:	

Prescriber's Signature (no stamps) Date IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addresses you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.