# Immune Deficiencies and Related Disorders

Delivery Need By: _____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other _____

## PATIENT INFORMATION

Patient Name: _____ ☐ Male
Address: _____ ☐ Female
City: _____ State: _____ Zip: _____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

## PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPA #: _____

## INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

## CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ inches Weight: _____ lbs

Allergies: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____
Medications On: _____
Other Notes: _____

## PRESCRIPTION INFORMATION

| Medication: | Dosage/Strength: | Directions: | Quantity: | Refills: |
|---|---|---|---|---|
| **Gammagard 10%®** | ☐ 10g/100ml vial<br>☐ 1g/10ml vial<br>☐ 25g/25ml vial<br>☐ 20g/200ml vial<br>☐ 30g/300ml vial<br>☐ 5g/50ml vial | ☐ Infuse _____ g via infusion pump every _____ weeks. | ☐ 1 month supply<br>☐ 90-Day Supply | ☐ 1 refill annually |
| **Gammagard S/D®** | ☐ 10g powder for injection<br>☐ 5g powder for injection | ☐ Infuse _____ grams ( _____ mL) OR _____ gram(s) per kg intravenously every _____ weeks<br>☐ Divide total dose over _____ days | ☐ 1 month supply<br>☐ 90-Day Supply | ☐ 1 refill annually |
| **Other** | | | | |

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____