Texas Centers for Infectious Disease Associates Pharmacy
FORT WORTH / 1025 College Ave., Fort Worth, TX 76104
Phone: 817-336-1640 Fax: 817-336-1643
DALLAS / 3410 Worth St., Ste. 780, Dallas TX 75246

Patient Information		Prescriber Information	
Patient name:		Prescriber name:	
DOB:	SSN:	DEA:	
Address:		NPI	License:
City:	State: Zip:	Address:	
Phone #:		City:	State: Zip:
Gender: ☐Male ☐Female ☐Other		Phone:	Fax:

Insurance Information: Complete entirely and fax front and back of patient's insurance card					
Primary Insurance	Subscriber	ID:	Name of insurer:		Phone:
Secondary Insurance	Subscriber	ID:	Name of insurer:		Phone:
Prescription card:	Name of insurer:	ID:	BIN:	PCN:	Group:

ICD 10 and Diagnosis:	Patient History	
ICD 10: ☐ D80.1 (Hypogammaglobulinemia) ☐ D83.9 (Common variable immunodeficiency) ☐ Other: _____	Weight ☐KG ☐LB	Height ☐IN ☐CM
For new Starts ☐ IVIG lab results ☐Titers ☐Vaccine Challenge	☐NKDA ☐Allergies:	

Provider Orders:					
	Drug	Dose	Route	Frequency	Refills
MEDICATION					
Pre-Medication (Given 30 minutes prior to infusion)	☐Acetaminophen 650mg PO ☐Diphenhydramine 25mg PO	☐Other: _____			

LABS	
Baseline labs on admission and then every six months while on therapy	☐CBC with differential ☐ CMP ☐ Igg Quantitative level, and IgG subclasses 1-4 ☐other: _____

Nursing: Evaluate and teach patient administration of IVIG, provide IV-line dressing change weekly and PRN, use SASH flushing protocol: S- Saline 10ml, A- administration medication, S- saline 10ml, H-Heparin 5ml (100units/ml). When on more than one dose per day patient to alternate lumens for administration

Prescriber Authorization: I authorize this pharmacy and its representative to act as my agent to secure coverage, dose IVIG based on labs, provide supplies necessary for infusion and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent.

Prescriber signature: _____ Date: _____