



# CareMed

Pharmaceutical Services

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## HemaCare IVIG Prescription Form

NeuroCare 

ImmunoCare 

OncoCare 

RheumaCare 

HepaCare 

### Patient Information

Last Name		First Name		SSN	DOB
Home Address		City		State	Zip
Home Phone		Work Phone		Parent/Guardian	
Shipping Address		City		State	Zip

### Pharmacy Insurance Information

Primary Insurance:	Rx Bin:	Secondary Insurance:	Rx Bin:
ID Number:	Group Number:	ID Number:	Group Number:

### Physician Information

Prescriber Name:		Licence:		DEA:		Office Contact:	
Address:		City:		State:	Zip:	Phone:	Fax:

### Diagnoses Information

Primary Dx:	ICD-9:	Secondary Dx:	ICD-9:
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### Patient Weight (Required)

### Delivery Information

Needed by:	Deliver to:
	<input type="checkbox"/> Patient's Home <input type="checkbox"/> Patient's Work <input type="checkbox"/> MD Office/Clinic <input type="checkbox"/> Other:

### IVIG Prescription Information (You may tape Prescriptions here prior to faxing)

IVIG	Dose in GRAMS	Frequency	Quantity	Refills
<input type="checkbox"/> Gammunex 10%				
<input type="checkbox"/> Gammagard 10%				
<input type="checkbox"/> Carimune				
<input type="checkbox"/> Octagam 5%				
<input type="checkbox"/> Winrho				
<input type="checkbox"/>				

### Flushes

<input type="checkbox"/> Normal Saline Flush
<input type="checkbox"/> Heparin Flush 100u/ml
<input type="checkbox"/> Heparin Flush 10u/ml
<input type="checkbox"/>
<input type="checkbox"/>

### Supportive Medications

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Epinephrine				
<input type="checkbox"/> Benadryl				
<input type="checkbox"/> Acetaminophen				
<input type="checkbox"/> Aspirin				
<input type="checkbox"/> Fexofenadine				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

## PRESCRIBER'S SIGNATURE REQUIRED

MD / NP / PA Signature: _____	Today's Date: _____
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