COTTRILL'S SP
1-844-268-8745

IMMUNE GLOBULIN (Ig) THERAPY PATIENT REFERRAL & Rx FORM

PLEASE INCLUDE ALL MEDICAL RECORDS AND LABS
PLEASE FAX TO 1-716-508-8482

PATIENT INFORMATION

Last Name ______________ First Name ______________ DOB ______________

Address ______________ City ______________ State ______________ Zip ______________

Gender: ☐ Male ☐ Female Height ______ Weight ______ Social Security # ______________

Home Phone ______________ Cell ______________ Email Address ______________

Allergies ______________ Emergency Contact Name ______________ Phone ______________

INSURANCE INFORMATION

Please provide a current copy of insurance card(s) or complete the following information

Primary Insurance ______________ Policy # ______________ Group # ______________ Phone ______________

Policy Holder's Name ______________ DOB ______________

Secondary Insurance ______________ Policy # ______________ Group # ______________ Phone ______________

Policy Holder's Name ______________ DOB ______________

CLINICAL INFORMATION

Primary Diagnosis: ______________ Diagnosis Code: ______

Secondary Diagnosis: ______________ Diagnosis Code: ______

PREVIOUS THERAPY

Medication ______________

☐ IV ☐ SC Rate ______________

MEDICATION

Medication	Dose	Quantity	Directions	Refills
______________ ______% ☐ IV ☐ SC	______ mg/kg ______ grams* *Round to nearest commerically available vial	1 month	☐ Infuse every ______ week(s) ☐ Other ______________ ______________ ______________ Infusion Sites ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 *Rate will be titrated per manufacturer recommendations (as tolerated)	____

Pre-medication/Anaphylaxis

Medication	Strength	Quantity	Directions	Refills
☐ Acetaminophen	☐ 325 mg ☐ 500 mg	____	Take ____ tablets by mouth prior to infusion.	____
☐ Diphenhydramine (Oral)	25 mg	____	Take ____ tablets by mouth prior to infusion.	____
☐ Diphenhydramine (Injectable)	50 mg/mL	____	Inject ____ mg prior to infusion.	____
☐ EMLA® Cream	2.5%/2.5%	____	Apply to affected area as needed.	____
☐ Epinephrine Autoinjector	☐ 0.15 mg ☐ 0.3 mg	2	Use as directed per anaphylaxis protocol.	____
☐ Normal Saline Flush	☐ 5 mL ☐ 10 mL	____	Flush IV with _____ mL before and after infusion.	____
☐ Other ______	______	____	Directions: ______________	____

Anaphylaxis Protocol/Instructions

☐ Follow Cottrill's anaphylaxis protocol as ordered (see attached).

Treatment Setting: ☐ Patient's home ☐ Physician's Office ☐ 1st dose to physician's office - remaining to patient home

SubQ Training: ☐ Cottrill's SP to coordinate infusion training ☐ Physician's office to provide infusion training

Cottrill's will provide all required supplies involved in the infusion process.

PHYSICIAN INFORMATION

Physician Name ______________ NPI# ______________

License # ______________ State ______________ DEA# ______________

Address ______________ City ______________ State ______________ Zip ______________

Phone ______________ Fax ______________ Office Contact ______________

______________ ______________ ______________

Product Selection Permitted **Dispense as Written** **Date**

Cottrill's will verify insurance benefits, initiate PA's and notify patient prior to admission of any out of pocket expenses or co-payments