

Phone: (888) 571-3100 • Fax: (800) 582-9315

Date: \_\_\_\_\_

**Demographics**

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex:  Male  Female  
Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_  
(c) \_\_\_\_\_ SS#: \_\_\_\_\_  
HT: \_\_\_\_\_ WT: \_\_\_\_\_ Next of Kin: \_\_\_\_\_

**Insurance Information: *MAY FAX DEMOGRAPHIC SHEET***

**Primary Insurance:** \_\_\_\_\_  
Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_  
**Secondary Insurance:** \_\_\_\_\_  
Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Prescribing Physician:**

Name: \_\_\_\_\_  
Address (please include facility name):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Specialty: \_\_\_\_\_  
License #: \_\_\_\_\_ UPIN #: \_\_\_\_\_  
DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
I have read this entire form and verify to its accuracy  Yes  
Date: \_\_\_\_\_

**Physician Orders: (Please check the following)**

**Hizentra 20% (200mg/mL):**  
Total weekly Dose= \_\_\_\_\_ grams  
Dispense: 4 week supply  
Refill x \_\_\_\_\_  
 **Gamunex-C 10% (100mg/mL):**  
Total weekly Dose= \_\_\_\_\_ grams  
Dispense: 4 week supply  
Refill x \_\_\_\_\_  
 **Gammagard Liquid 10% (100mg/mL):**  
Total weekly Dose= \_\_\_\_\_ grams  
Dispense: 4 week supply  
Refill x \_\_\_\_\_

**Other Orders: (Please check all that apply)**

Pharmacist to determine least number of sites for product administration based on manufacturer recommendations/restrictions  
 0.9% Sodium Chloride flush to verify correct SC needle placement  
 **EpiPen (dose based on weight/age)**  
*Sig: Use as directed for anaphylactic reaction*  
 **Acetaminophen 650 mg**  
*Sig: Take by mouth every 4-6 hours PRN fever and/or headache*  
 **Diphenhydramine 25 mg**  
*Sig: Take by mouth every 4-6 hours PRN itching*

**Diagnosis: (Please check one of the following)**

IgG Level: \_\_\_\_\_ Date: \_\_\_\_\_  
 279.00 Hypogammaglobulinemia  
 279.04 Congenital Hypogammaglobulinemia  
 279.05 Immunodeficiency with increased IgM  
 279.06 Common Variable Immune Deficiency (CVID)  
 279.12 Wiskott-Aldrich syndrome  
 279.2 Severe Combined Immunodeficiency (SCID)  
 Other: \_\_\_\_\_  
ICD-9 Code: \_\_\_\_\_

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**Please to email this form automatically, or attach manually to: [referrals@medprorx.com](mailto:referrals@medprorx.com)**

**Or Fax Completed Copies of the Following to MedPro Rx @ 1-800-582-9315: (1) Referral Form and (2) Your Insurance Card(s)**

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