



Patient Information

Patient Name _____
Date of Birth _____ Male Female
Address _____ Apt # _____
City _____ State _____ Zip _____
Phone Home _____
Work _____ Cell _____
Social Security # _____
Allergies _____ NKA
Weight _____ kg lb Blood Pressure _____
Emergency Contact Name _____
Phone _____
Please attach copy of insurance information or copy of insurance cards (both sides).

Shipping Information

Patient's Home Physician's Office
 Other _____
Date Medication Needed _____

Physician Information

Physician Name _____
Office Contact Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____
Physician Signature _____
Date _____
 Dispense as written Generic substitution permitted

Diagnosis/Medical Information

ICD9 Code:
Primary Diagnosis: _____
ICD9 Code: _____
Secondary Diagnosis: _____
ICD9 Code: _____
 Use of previous SCIG product (include code) _____
IgA Level: _____ Date: _____ IgG Level: _____ Date: _____
Hct: _____ Date: _____ Platelets Count: _____ Date: _____
Additional History: _____

Prescription Information

Treatment Settings & Patient Training
Step 1 Initial Treatment Setting:
 Physician Office Outpatient Clinic Inpatient Home
Step 1A Product will be supplied by:
 Physician Access Specialty Pharmacy Other _____
Step 2 Patient Training: Do you want the Specialty Pharmacy to train the patient? Yes No
Step 3 Final Treatment Setting:
 Physician Office Outpatient Clinic Inpatient Home
Step 3A Product will be supplied by:
 Physician Access Specialty Pharmacy Other _____
Initial Dose 100mg – 200mg/kg SC once weekly
IVIG Conversion:
Weekly SCIG dose = IVIG dose x 1.37 ÷ IVIG weekly interval originally given
Total monthly grams of Vivalobin® _____ ÷ 0.160 grams per ml = _____ ml per month
Divide ml per month into appropriate weekly dose and round to appropriate vial size(s)

Dispense:
Quantity _____ Refill _____ times

Need Supplies: Please specify _____
Ancillary supplies/kits provided as needed for administration.