## Xembify® Infusion

**Fax Referral To:**
**877-438-9380**

| Birmingham,AL | Huntsville, AL | Knoxville, TN | Nashville, TN | Chantilly, VA |
|---|---|---|---|---|
| F: 205-271-9971 | F: 256-417-6408 | F: 865-934-0249 | F: 615-645-4791 | F: 703-935-2061 |

## PREVIOUS ADMINISTRATION

**Please provide the following information:** Last Infusion Date: ____________________ Next Infusion Date: ____________________

## Patient Information

Patient Name:____________________________ DOB: ________________ Sex: M F Height: ______ Weight: ______________________

Phone Number: _______________________________ Email Address: ___________________________________________________

Allergies: ___________________________________________________ Is the patient Diabetic: Y N ICD-10 Code: ____________________

Emergency Contact:______________________________________________ Phone Number: _______________________________________________

***Primary Diagnosis:*** _____Other:______________________________________________________________________________________

_________________________________________________________________________________________________

**Please attach the following: 1. Clinical progress notes and H&P to support diagnosis 2. Copy of the patient's Insurance Card 3. Copy of any recent Labs, etc.**

**Lab Orders:** _________________________________________________________________________________________

## Physician Information

Prescribing Physician: ________________________________ Practice Name: ________________________________

Practice Phone: ________________________________ Practice Fax: ________________________________

Email: ________________________________ Office Contact: ________________________________

Co-managing Physician: ________________________________ Phone/Email: ________________________________

## Medication Order

***Medication:*** **Xembify®** *(immune globulin subsutaneous human-klhw) 20%*

________ # Refills (Dispense 1 month supply. Refill x 1 year unless noted otherwise.)

***New Start:***

Infuse ______________ gram(s)
OR ______________ mg per kg OR
OR ______________ grams per kg subcutaneously

Once weekly Every 2 weeks
Other frequency: ____________________________________________
(where clinically appropriate, round to the nearest vial size)

Infuse total dose of immune globulin subcutaneously in 1 to multiple sites via infusion pump as tolerated. Infusion rates per manufacturer recommendation as tolerated.

Diphenhydramine 25mg by mouth for mild infusion reactions, may increase to 50mg for history of moderate to severe (contraindicated in patients with (myasthenia gravis)
Acetaminophen 650 mg PO administered 30 min prior to infusion **adjust to patient's needs.*
Other: ________________________________________________________________________

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.

**By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)**

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

______________________ ____________________________________________
Physician's NPI# Physician's Address

____________________________________ ______________________
Prescriber's Signature Date

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