



Fax: 1-866-458-9245

Phone: 1-866-458-9246

E-Prescribe: Exactus Pharmacy Solutions

Intravenous immunoglobulin (IVIG) is available upon Prior Approval through Envision.
Please call 1-855-872-0005 before ordering from Exactus and using this form

Patient Information

Name (First, MI, Last) _____ Sex ☐ M ☐ F DOB (MM/DD/YYYY) _____
Address _____ City _____
State _____ ZIP _____ Email _____
Home/Cell Phone _____ Work Phone _____ Best Contact Time _____

Insurance Information (Complete this section or provide a copy of all insurance cards Front AND Back)

Primary Insurance _____	Secondary Insurance _____
Cardholder _____	Cardholder _____
Relationship to Cardholder _____	Relationship to Cardholder _____
Insurance Company Phone _____	Insurance Company Phone _____
Policy# _____	Policy# _____
Group# _____	Group# _____
Prescription Drug Insurer _____	Prescription Drug Insurer _____

Prescriber Information (SPECIAL NOTE: New York Prescribers please submit prescription on an original NY State prescription blank. For all other states, if not faxed, prescription must be submitted on state-specific blank, if applicable for your state.)

Prescriber Name (First, Last) _____ Specialty _____
Practice Name _____ Office Contact _____
Address _____
City _____ State _____ ZIP _____
Phone _____ Fax _____
Medicaid/Medicare Provider# _____ Tax ID# _____
State License# _____ UPIN/NPI# _____

Clinical Information

Primary Diagnosis code (required) _____
Secondary Diagnosis (optional) _____ Date of Diagnosis or Years with Disease _____
Prior Medications _____

Prescription Information (The prescription is only valid if received by fax.)

☐ Bivigam™	☐ Flebogamma® DIF	☐ Gammaked™	☐ Octagam®
☐ Carimune® NF	☐ Gammagard® Liquid	☐ Gammaplex®	☐ Privigen®
☐ Flebogamma®	☐ Gammagard® S/D	☐ Gammunex®-C	☐ QTY _____
			☐ Refills _____

SIG: _____

Ship to (as indicated by applicable address information above): ☐ Prescriber ☐ Patient

Requested Ship Date _____

Prescriber Signature (Dispense as Written) _____ DATE _____

Supervising Physician Signature (if applicable) Name _____ DATE _____