



Immunology IVIG/SCIG Enrollment Form

Phone: 909-266-0016

Fax: 909-284-9140

Rep: _____

Urgent Request

PATIENT INFORMATION

Patient Name:		<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date:	
Date of Birth:		Height:		Weight:	<input type="checkbox"/> kg <input type="checkbox"/> lbs
Phone:		Mobile Phone:		Email:	
First Dose of IVIG/SCIG	<input type="checkbox"/> YES <input type="checkbox"/> NO	Prior IG products tried?			

PRIMARY DIAGNOSIS INFORMATION (ICD 10 diagnosis codes):

Primary ICD-10 Code for IG Diagnosis: <input type="checkbox"/> D80.1 Nonfamilial hypogammaglobulinemia <input type="checkbox"/> D80.2 Selective Deficiency of immunoglobulin A [IgA] <input type="checkbox"/> D80.3 Selective Deficiency of immunoglobulin G [IgG] subclasses <input type="checkbox"/> D80.4 Selective Deficiency of immunoglobulin M [IgM] <input type="checkbox"/> D80.6 Antibody deficiency with near-normal immunoglobulins or with hyperimmunoglobulinemia	<input type="checkbox"/> D80.7 Transient hypogammaglobulinemia of infancy <input type="checkbox"/> D80.8 Other immunodeficiencies with predominantly antibody defects Kappa light chain deficiency <input type="checkbox"/> D80.9 Immunodeficiency with predominantly antibody defects, unspecified <input type="checkbox"/> D81.4 Nezelof's syndrome	<input type="checkbox"/> D82.1 Di George's syndrome Pharyngeal pouch syndrome Thymic aplasia Thymic aplasia or hypoplasia with immunodeficiency <input type="checkbox"/> D82.2 Immunodeficiency with short-limbed stature <input type="checkbox"/> D82.3 Immunodeficiency following hereditary defective response to Epstein-Barr virus X-linked lymphoproliferative disease	<input type="checkbox"/> D82.4 Hyperimmunoglobulin E [IgE] syndrome <input type="checkbox"/> D82.8 Immunodeficiency associated with other specified major defects <input type="checkbox"/> D82.9 Immunodeficiency associated with major defect, unspecified <input type="checkbox"/> D84.9 Immunodeficiency, unspecified
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IMMUNE GLOBULIN INFORMATION:

Route of administration: IVIG SCIG

Preferred IVIG Brand: Pharmacist to determine Gammagard 5% Gammagard 10% Gammaked 10% Gamunex-C 10%
 Octagam 5% Octagam 10% Panzyga 10% Privigen 10%

Preferred SCIG Brand Pharmacist to determine Cutaquig 16.5% Hizentra 20% Xembify 20%

Immune Globulin Product	Dose	Frequency	Quantity	Refills

Pre-treatment Information: Nurse to administer the indicated medications 30 -60 minutes prior to IG infusion

Acetaminophen 650 mg PO Diphenhydramine: 25 mg PO **OR** 50 mg PO Diphenhydramine: 25 mg IV push **OR** 50 mg IV push
 Hydrocortisone 100 mg slow IV push Methylprednisolone 125 mg slow IV Push NaCl 0.9% _____
 Other _____

ANAPHYLAXIS ORDER INFORMATION

Adult (>30kg) <input type="checkbox"/> Epinephrine 1:1000 (0.3mg) PRN for anaphylactic reaction <input type="checkbox"/> Diphenhydramine 50mg RN to give IV or IM in case of mild allergic reaction <input type="checkbox"/> Other:	Pediatric (15 – 30kg) <input type="checkbox"/> Epinephrine 1:1000 (0.15mg) PRN for anaphylactic reaction <input type="checkbox"/> Diphenhydramine _____mg, usual dose 1-2 mg/kg (up to 50mg), RN to give IV or IM in case of mild allergic reaction <input type="checkbox"/> Other:
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DELIVERY INSTRUCTIONS:

<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Other:	Date Medication Needed:
<input type="checkbox"/> Patient's Home	Address:	
	City/State/Zip:	

PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name:	Office Contact:	
Phone:	Fax:	Specialty:
Address:	City/State/Zip:	
NPI#:	DEA#:	License#:

PLEASE ALSO PROVIDE THE FOLLOWING CLINICAL INFORMATION TO ASSIST WITH THE PRIOR AUTHORIZATION PROCESS:
 Antibiotic use history Chart Notes documented diagnosis Qualitative/quantitative serum IG levels

*** Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature: _____ Date: _____

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