IVIG/SCIG Enrollment Form

Fax: 909-284-9140
Phone: 909-266-0016
□ **Urgent Request**
Rep: _____

PATIENT INFORMATION

Patient Name:	□ Male	□ Female	Date:		
Date of Birth:	Height:		Weight:	□ kg	□ lbs
Phone:	Mobile Phone:		Email:		
Fist Dose of IVIG/SCIG	□ YES	□ No	Prior IG products tried?		

PRIMARY DIAGNOSIS INFORMATION (ICD 10 diagnosis codes):

Primary ICD-10 Code for IG Diagnosis:

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 □ Hizentra 20% □ Xembify 20%

IMMUNE GLOBULIN INFORMATION:

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 □ Other _____

ANAPHYLAXIS ORDER INFORMATION

Adult (>30kg)
□ Epinephrine 1:1000 (0.3mg) PRN for anaphylactic reaction
□ Diphenhydramine 50mg
RN to give IV or IM in case of mild allergic reaction
□ Other:

Pediatric (15 – 30kg)
□ Epinephrine 1:1000 (0.15mg) PRN for anaphylactic reaction
□ Diphenhydramine_____mg, usual dose 1-2 mg/kg (up to 50mg),
RN to give IV or IM in case of mild allergic reaction
□ Other:

DELIVERY INSTRUCTIONS:

□ Physician's Office	□ Other:	Date Medication Needed:
	Address:	
□ Patient's Home	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:

Immune-deficiency diagnosis:
· Antibiotic use history
· Chart Notes documented diagnosis
· Qualitative/quantitative serum IG levels

Neurological diagnosis:
· Chart Notes documented diagnosis
· Nerve conduction tests

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: _____