INTRA VENEOUS IMMUNOGLOBULINES ENROLLMENT FORM

PATIENT INFORMATION

Last Name ______ First Name ______

Social Security No ______ Date of Birth ______

Sex □ M □ F Weight_____ Height_____ Allergies_________

Home Phone ______ Work/Mobile ______

Home Address ______

City ______ State ______ Zip ______

PATIENT INSURANCE INFORMATION

Primary Medical Insurance ______ Medical Insurance Phone ______

Subscriber Name ______

Policy No ______ Group No ______

Prescription Card Bin # ______ PCN # ______

TREATMENT ARRANGEMENTS

•Start Date:______________ Ship Meds □ Home □ Doctor's Office

Teaching by: □ Home Health □ Doctor's Office □ Other:_____________

PRESCRIPTION INFORMATION

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: (ICD-9 CM Code Plus Description) Date of Diagnosis: ______________________

PID 270.00, ITP 287.31, CLL 204.1, Kawasaki Syndrome 446.1, NOS 279.3 **For off Label use call office**

MEDICATIONS

GAMMAGUARD 10% **GAMUNEX 10%** **CARIMUNE 10%** **FLEBOGAMMA 5%**

OCTAGAM 5% **GAMMAKED 10%**

Dose: ________________ GMs, IV over_________hours every 21/28 Days

- IVIG will be tapered up over 40-60 minutes via pump program.
- IVIG to run no faster than 10 gm/hr unless specified by physician
- Saline PFS 10ml Flush before and after infusion #qs Refill prn
- Heparin 100u/ml 3-5ml Flush after infusion #qs Refill prn

Refill X_____________ Months

□ **HIZENTRA 20%**

Dose: _______________GMs to be infused simultaneously into □1 □2 □3 □4 (Check one) subcutaneous sites using a pump *(Freedom 60® Syringe Infusion System or other)* over __________hours

SQIg needle sets requested:

Gauge *(check one)* □24 □26 □27 Length *(Check one)* □4mm □6mm □9mm □12mm □14mm

Number of weeks of Hizentra requested________________*(Must be between 1-4 weeks)*

Total grams of Hizentra requested _______grams *(upto 4 week's supply available based on patient's body weight) No authorized refills. Prescription is valid for one time only with no refills.*

□ ***Skilled Nursing visit for self injection training and one additional visit with next dose if needed.***

Physician Signature: ______________________________ □ **DAW (Dispense as Written) Date:** ______________

Physician Name: ____________________ **Phone:** ______________ **Fax:** ______________ **Office Contact:** ____________

Physician Address: ______________________________ **NPI:** ______________ **DEA:** ______________

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FAX TO (855) - 822 - 7838

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