

Prescription & Enrollment Form Immune Globulins (IVIG)



(800) 962-6339 Office
(866) 755-6339 Fax

Patient Information

Last Name	First Name
Social Security #	Date of Birth
Parent or Guardian	
Home Phone	Other Contact Phone
Home Address	
City, State, Zip	

Insured Information

Primary Insurance (Fax copy of card - both sides)	
Subscriber's Name	Relationship to Patient
Policy #	Group #
Primary Insurance Phone	
Prescription Card (Fax copy of card - both sides)	
Secondary Insurance	Policy #

DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnosis)

<input type="checkbox"/> 204.9 Chronic Lymphocytic Leukemia	<input type="checkbox"/> 279.0 Deficiency of humoral immunity
<input type="checkbox"/> 279.00 Hypogammaglobulinemia, unspecified	<input type="checkbox"/> 279.3 Immunity Deficiency (NOS)
<input type="checkbox"/> 279.06 Common Variable Immunodeficiency (CVID)	<input type="checkbox"/> 446.1 Kawasaki disease
<input type="checkbox"/> 287.31 Idiopathic Thrombocytopenia Purpura (ITP)	Platelet count _____ date _____
<input type="checkbox"/> 357.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	Allergies: _____
<input type="checkbox"/> IgG level _____ date _____	
<input type="checkbox"/> Other, Specify _____	Ht. _____ Wt. _____
Previous corticosteroid therapy <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> intolerance <input type="checkbox"/> not applicable	Flushing protocol: _____
New to therapy <input type="checkbox"/> yes <input type="checkbox"/> no If no, date therapy began _____	Date of diagnosis: _____

PREVIOUS MEDICATIONS (Please specify dosage & time on therapy)

Medication Strength & Dose	Dates of Therapy	Reason for Discontinuing

PRE-MEDICATIONS

<input type="checkbox"/> EMLA® <input type="checkbox"/> ElaMax® 4% <input type="checkbox"/> Lidocaine 4% (topical cream to be applied topically to site for venous accessing prn)
<input type="checkbox"/> Other: _____

PRESCRIPTION INFORMATION

Medication	Dose	Frequency	Quantity	Refills
<input type="checkbox"/> Carimune® NF				
<input type="checkbox"/> Flebogamma® 5%				
<input type="checkbox"/> Gammagard® Liquid 10%				
<input type="checkbox"/> Gammagard® S/D				
<input type="checkbox"/> Gamunex®				
<input type="checkbox"/> Hizentra® SCig 20%				
<input type="checkbox"/> Octagam® 5%				
<input type="checkbox"/> Privigen® 10%				
<input type="checkbox"/>				

Adverse Reaction Medications to be maintained in the patient's home & administered as necessary: <input type="checkbox"/> Diphenhydramine 25-50 mg PO or IV prn allergic reaction: _____ <input type="checkbox"/> Epinephrine 1:1000 Subcut IM prn severe allergic reaction: _____ Adults: 0.02 mg per kg up to 0.5 mls Pediatrics greater than 10 lbs: 0.01 mg per kg up to 0.3 mls	Method of Administration: <input type="checkbox"/> PIC <input type="checkbox"/> Port <input type="checkbox"/> IV
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DELIVER TO: Delivery Method: Gravity Infusion Pump

<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Patient's Home	<input type="checkbox"/> Other	Date Meds Needed: _____
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Physician's Name (Please Print) _____

Physician's Address _____

Phone _____ Fax _____

Dr.'s Office Contact Name _____

Physician's Signature _____ Date _____

Physician's DEA# _____

License # _____ NPI _____

Fax completed form to Medex BioCare (866) 755-6339