



## IVIG ENROLLMENT FORM

**FAX REFERRAL TO:**

**1-888-801-0404**

**PHONE: 1-888-570-9077**

Administration Location:

Patient Home

Prescriber Office

Date : \_\_\_\_\_

**PATIENT INFORMATION**

(Complete the following *or send patient demographic sheet*)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M - F

**INSURANCE INFORMATION**

**Primary Insurance/Prescription Card:**

PLEASE FAX COPY OF INS CARD (front and back if available)

**Secondary Insurance/Prescription Card:**

PLEASE FAX COPY OF INS CARD (front and back if available)

**DIAGNOSIS / ICD 10 CODE**

CIDP

Myasthenia Gravis

Polymyositis

Guillain-Barre Syndrome

Dermatomyositis

CVID

Multifocal Motor Neuropathy

Other:

**PRESCRIBER INFORMATION**

Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Office Fax: \_\_\_\_\_

NPI#: \_\_\_\_\_

Key Office Contact: \_\_\_\_\_

**CLINICAL INFORMATION**

Weight: \_\_\_\_\_ kg or \_\_\_\_\_ lbs.

Height: \_\_\_\_\_ inches (if over 250 lbs.)

Venous Access: Type \_\_\_\_\_

Use Existing Venous Access for IVIG Infusion?:  Yes  No

History of:  Cardiac Disease  Diabetes  Renal Dysfunction  
 Clotting Disorders  Stroke

IgA Deficient:  Yes  No

Allergies: \_\_\_\_\_

**IVIG PRESCRIPTION**

MEDICATION	STRENGTH & DIRECTIONS FOR USE	QUANTITY	REFILLS
<input type="checkbox"/> <b>Gamunex-C®</b>	IVIG Dose: _____ grams/kg = _____ grams (round to nearest vial size) infuse intravenously (Range:0.2-2 grams/Kg)		
<input type="checkbox"/> <b>Gammagard®</b>	<input type="checkbox"/> Repeat dose daily x _____ consecutive days total, repeat dose <input type="checkbox"/> monthly x _____ months <input type="checkbox"/> Repeat dose weekly x _____ weeks total <input type="checkbox"/> Repeat dose monthly x _____ months total		
<input type="checkbox"/> <b>Other:</b>	First Dose: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>START OF CARE DATE:</b> _____ / _____ / _____		

**PRE-MEDICATIONS**

MEDICATION	STRENGTH	DIRECTIONS FOR USE	QUANTITY	REFILLS
<input type="checkbox"/> <b>Diphenhydramine</b>	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg	Take one dose by mouth ½ hour prior to administration of IVIG.		
<input type="checkbox"/> <b>Acetaminophen</b>	<input type="checkbox"/> 325 mg <input type="checkbox"/> 500 mg	Take _____ mg by mouth ½ hour prior to administration of IVIG.		
<input type="checkbox"/> <b>NaCl Hydration</b>	<input type="checkbox"/> 0.9%	<input type="checkbox"/> Hydrate with IV Infusion of _____ ml prior to administration of IVIG. <input type="checkbox"/> Hydrate with IV Infusion of _____ ml Pre and post infusion		
<input type="checkbox"/> <b>Other</b>				

**INFUSION SUPPLIES**

MEDICATION	STRENGTH & DIRECTIONS FOR USE	QUANTITY	REFILLS
<input type="checkbox"/> <b>NaCl 0.9%/D5W</b>			
<input type="checkbox"/> <b>Heparin 100 U/ML Flush</b>	Flush line/port with 3-5 ml for PIV and 5-10 ml for central line/port.		
<input type="checkbox"/> <b>Anaphylaxis Kit</b>	Benadryl IV 50mg/Epinephrine 1:1000/NACL 500ml bag		
<input type="checkbox"/> <b>Labs</b>			

\_\_\_\_\_  
 Prescriber Signature

\_\_\_\_\_  
 (Date)

I authorize Focus Rx staff or its representatives to act as an agent to initiate and execute any insurance company prior authorization or precertification on my behalf.

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