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
☐ Polymyositis
☐ Dermatomyositis
☐ Multifocal Motor Neuropathy
☐ Myasthenia Gravis
☐ Guillain-Barre Syndrome
☐ CVID
☐ 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
☐ **Gamunex-C®** ☐ **Gammagard®** ☐ **Other:**	IVIG Dose: _____ grams/kg = _____ grams (round to nearest vial size) infuse intravenously (Range:0.2-2 grams/Kg) ☐ Repeat dose daily x _____consecutive days total, repeat dose ☐ monthly x ___months ☐ Repeat dose weekly x _____weeks total ☐ Repeat dose monthly x _____months total First Dose: ☐ Yes ☐ No ☐ **START OF CARE DATE**: _____/_____/_____		

PRE-MEDICATIONS

MEDICATION	STRENGTH	DIRECTIONS FOR USE	QUANTITY	REFILLS
☐ **Diphenhydramine**	☐ 25 mg ☐ 50 mg	Take one dose by mouth ½ hour prior to administration of IVIG.		
☐ **Acetaminophen**	☐ 325 mg ☐ 500 mg	Take _____ mg by mouth ½ hour prior to administration of IVIG.		
☐ **NaCl Hydration**	☐ 0.9%	☐ Hydrate with IV Infusion of _____ ml prior to administration of IVIG. ☐ Hydrate with IV Infusion of _____ ml Pre and post infusion		
☐ **Other**				

INFUSION SUPPLIES

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

_____
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.*