SCIG 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
☐ ☐
☐ ☐
☐ ☐ 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:_____ Date: _____

History of: ☐ Cardiac Disease ☐ Diabetes ☐ Renal Dysfunction ☐ Clotting Disorders ☐ Stroke

Labs attached:
☐ BUN/ SCr
☐ Is the patient IgA Deficient? If Yes, please attach labs
☐ Detailed Infection history
☐ Baseline IgG (including subclasses)
☐ Immune response to vaccinations (including report)

Allergies:_____

SCIG PRESCRIPTION

MEDICATION	STRENGTH & DIRECTIONS FOR USE	QUANTITY	REFILLS
☐ **Hizentra®**	Total weekly dose of _____grams (total _____ml's): ☐Please Convert to **1 : 1.37** ratio *or* ☐ Administer as **1 : 1** ratio ☐ Infuse into 1 - 2 - 3 - 4 (circle one) subcutaneous sites ☐ Dosed Once per week OR ☐ _____ times per _____ weeks ☐ *IVIG* dose (Brand_____) needed before SCIg initiated? ☐ No ☐ Yes: Dose _____gram (_____gm / kg) x 1 dose ☐ **START OF CARE DATE**: _____/_____/_____		
☐ **Other Brand**	☐Gamunex-C® ☐ Gammagard Liquid® ☐ Other:_____ Total weekly dose of _____grams (total _____ml's): ☐Please Convert to **1 : 1.53** ratio *or* ☐ Administer as **1 : 1** ratio ☐ Infuse into 1 - 2 - 3 - 4 (circle one) subcutaneous sites ☐ Dosed Once per week OR ☐ _____ times per _____ weeks ☐ *IVIG* dose needed before SCIg initiated? ☐ No ☐ Yes: Dose _____gram (_____gm / kg) x 1 dose ☐ **START OF CARE DATE**: _____/_____/_____		

INFUSION SUPPLIES

MEDICATION	STRENGTH & DIRECTIONS FOR USE	QUANTITY	REFILLS
☐ **Include Supplies**	• Freedom 60 pump administration over____hours using SCIg needles 4 – 6 – 9 – 12 – 14 mm length (circle one) • Anaphylaxis Kit (protocol based on route of administration) • For Independent patients: One Epinephrine auto injector sig: Administer IM for one dose for severe allergic reaction (includes wheezing, difficulty of breathing, swelling of eyelids, lips or throat). Refillable for 1 year		
Treatment Setting	Has patient received Ig before? ☐ Yes ☐ No, initial treatment to be done in ☐ Physician office ☐ Home		
☐Other			

_____
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.*