



## 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
<input type="checkbox"/> <b>Hizentra®</b>	Total weekly dose of _____ grams (total _____ ml's): <input type="checkbox"/> Please Convert to <b>1 : 1.37</b> ratio or <input type="checkbox"/> Administer as <b>1 : 1</b> ratio <input type="checkbox"/> Infuse into 1 - 2 - 3 - 4 (circle one) subcutaneous sites <input type="checkbox"/> Dosed Once per week OR <input type="checkbox"/> _____ times per _____ weeks <input type="checkbox"/> IVIG dose (Brand _____) needed before SCIG initiated? <input type="checkbox"/> No <input type="checkbox"/> Yes: Dose _____ gram (_____ gm / kg) x 1 dose <input type="checkbox"/> <b>START OF CARE DATE:</b> ____/____/____		
<input type="checkbox"/> <b>Other Brand</b>	<input type="checkbox"/> Gamunex-C® <input type="checkbox"/> Gammagard Liquid® <input type="checkbox"/> Other: _____ Total weekly dose of _____ grams (total _____ ml's): <input type="checkbox"/> Please Convert to <b>1 : 1.53</b> ratio or <input type="checkbox"/> Administer as <b>1 : 1</b> ratio <input type="checkbox"/> Infuse into 1 - 2 - 3 - 4 (circle one) subcutaneous sites <input type="checkbox"/> Dosed Once per week OR <input type="checkbox"/> _____ times per _____ weeks <input type="checkbox"/> IVIG dose needed before SCIG initiated? <input type="checkbox"/> No <input type="checkbox"/> Yes: Dose _____ gram (_____ gm / kg) x 1 dose <input type="checkbox"/> <b>START OF CARE DATE:</b> ____/____/____		

**INFUSION SUPPLIES**

MEDICATION	STRENGTH & DIRECTIONS FOR USE	QUANTITY	REFILLS
<input type="checkbox"/> <b>Include Supplies</b>	<ul style="list-style-type: none"> <li>Freedom 60 pump administration over _____ hours using SCIG needles 4 – 6 – 9 – 12 – 14 mm length (circle one)</li> <li>Anaphylaxis Kit (protocol based on route of administration)</li> <li>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</li> </ul>		
<b>Treatment Setting</b>	Has patient received Ig before? <input type="checkbox"/> Yes <input type="checkbox"/> No, initial treatment to be done in <input type="checkbox"/> Physician office <input type="checkbox"/> Home		
<input type="checkbox"/> 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.

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