IG and General Immune Disorders Enrollment Form

Date: _____

Century Specialty Script

Fax Referral To: 877-521-5353

Phone: 800-521-3949

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
Date of Birth:___ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA#:_____ NPI#: _____
Contact Person: _____

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____ ID#:_____ Group:_____
Secondary Insurance:_____ ID#:_____ Group:_____
Prescription Card: _____ ID#:_____ BIN:_____ PCN:_____ Group: _____

DIAGNOSIS (ICD-10)

Neurological

☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ G61.82 Multifocal Motor Neuropathy (MMN)
☐ G61.0 Guillain-Barre ☐ G25.82 Stiff-Person Syndrome
☐ G35 Multiple Sclerosis ☐ M33.20 Polymyositis
☐ G70.01 Myasthenia Gravis w/Exacerbation
☐ Other: _____

Immunological

☐ Primary Immune Deficiency – ***Please specify ICD-10 Code:*** _____
☐ D80.9 Deficiency of Humoral Immunity
☐ D83.9 Common Variable Immunodeficiency
☐ D89.9 Immune Mechanism Disorder ☐ D81.9 Immune Deficiency NOS
☐ D69.3 Idiopathic Thrombocytopenia ☐ D80.1 Hypogammaglobulinemia
☐ Other: _____

CLINICAL INFORMATION *(Please attach all clinical information, lab results, and other medical history documents)*

Patient Weight:_____Kg/Lbs Height:____Inches/CM Allergies:_____
Has patient previously received IVIG ☐ Yes ☐ No Line Access: ☐ PIV ☐ PICC ☐ PORT Needs by Date: _____

Medication	Dose	Directions
Intravenous ☐ **Gammagard® Liq. 10%** ☐ **Privigen® 10%** ☐ **Gamunex-C® 10%** ☐ **Octagam® 5%** ☐ **Gammaked® 10%** ☐ **Octagam® 10%** ☐ **Bivigam®** ☐ **Gammagard® S/D** ☐ **Other:** _____ ☐ **Panzyga® 10%**	_____grams **OR**_____gram(s) per kg *(Pharmacy to round to nearest vial size)* Infuse total dose OVER_____day(s); Every _____week(s) for: ☐ 1 month ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other_____	Infuse total dose of Immunoglobulin intravenously based on manufacturer recommend infusion rate as tolerated. Infuse via: ☐ Infusion Pump ☐ Gravity Excludes Medicare D
Medication	**Dose**	**Directions**
Subcutaneous ☐ **Gammagard® Liq. 10%** ☐ **Xembify® 20%** ☐ **Gamunex-C® 10%** ☐ **Cutaquig® 16.5%** ☐ **Gammaked® 10%** ☐ **Hizentra® 20%** ☐ **HyQvia® 10%**	_____grams **OR**_____gram(s) per kg *(Pharmacy to round to nearest vial size)* Infuse total dose OVER_____day(s); Every _____week(s) for: ☐ 1 month ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other _____	Infuse total dose of Immunoglobulin subcutaneously in one or more infusion sites via infusion pump based on manufacturer recommend infusion rate as tolerated. Other: _____ _____

☐ **Labs** baseline and then every 6 months: BUN/Creatinine

Premedication to be given 30 minutes prior to infusion:
☐ Diphenhydramine 25-50 mg po – 25mg #2 per dose
☐ Diphenhydramine 25-50 Slow IV-Push – 50mg vial #1 per dose
☐ Acetaminophen 325-650 mg po – 325mg #2 per dose
☐ Ketorolac 30mg Slow IV-Push – 30mg/ml vial #1 per dose
☐ Other: _____

IV Access Flush Order / EpiPen® Order: ***(Infusion supplies per pharmacy protocol)***
☐ NaCl 0.9% 5-10ml IV before and after infusion
☐ Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN
☐ Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN
☐ All infusion supplies necessary to administer the medication
☐ EpiPen® 0.3mg auto-injector for severe anaphylactic reaction for patient weighing ≥ 30kg. EpiPen Jr. ® 0.15mg for patients weighing under 30kg

By signing below, I certify that above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

_____ _____ _____ _____
Dispense as Written Date Substitution Allowed Date