IVIG and General Immune Disorders Enrollment Form	Century Specialty Script Fax Referral To: 877-521-5353 Phone: 800-521-3949	
Date: _____ ☐ Current Patient ☐ New Patient		

Patient Information

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
DOB: _____ Gender: ☐M ☐ F

Prescriber Information

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

Insurance Information

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)
☐ G61.8 Multifocal Motor Neuropathy (MMN)
☐ G61.0 Guillian-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: _____

Medications	Dose	Directions
Interavenous ☐ Bivigam® 10% ☐ Flebogamma® 5% ☐ Flebogamma® 10% ☐ Gammagard® Liq 10% ☐ Gammagard® S/D ☐ Gammaked® 10% ☐ Gamunex-c® 10% ☐ Octagam® 5% ☐ Octagam® 10% ☐ Panzyga 10% ☐ Privigen® 10% ☐ Other: _____	_____ 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

Medications	Dose	Directions
Subcutaneous ☐ Gammagard® Liq. 10% ☐ Xembify 20% ☐ Gamunex-c® 10% ☐ Other: _____ ☐ 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: _____

Premedication to be given 30 minutes prior to infusion:
☐ Acetaminophen 325-650mg po – 32mg #2 per dose
☐ Diphenhydramine 25-50mg po – 25mg #2 per dose
☐ Diphenhydramine 25-50mg Slow IV-Push – 50mg vial #1per dose
☐ Ketorolac 30mg Slow IV-Push – 30mg/mL vial #1per dose
☐ LMX 4 Cream – Apply topically to insertion site as needed. #1tube
☐ Other: _____

IV Access Flush Order/EpiPen® Order: (Infusion supplies per pharmacy protocol)
☐ 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
☐ 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
☐ NaCl 0.9% 5-10mL IV before and after infusion

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

Prescriber Signature: _____ DAW (Dispense as Written) Date: _____