



Immune Globulins (Ig) Enrollment Form

Fax Referral Form To: 1-781-805-8245
 Specialty Pharmacy Phone: 1-844-319-7588

Please fill out the following 6 areas to submit a referral:

1 PATIENT INFORMATION		
Patient Name		Date of Birth
Address		Primary Phone
City	State	Alternate Phone
ZIP	Gender M F	Email
Primary Language		

2 PRESCRIBER INFORMATION	
Prescriber's Name	License #
DEA #	NPI #
Group or Hospital Name	Contact Person
Address	Phone
City, State, ZIP	Fax

3 INSURANCE INFORMATION
Please fax copy of prescription and insurance cards with applicable pre-authorization approvals with this form, if available.

4 DIAGNOSIS AND CLINICAL INFORMATION		
Needs by Date: _____	First Fill Ship to: <input type="checkbox"/> Patient <u>OR</u> <input type="checkbox"/> Medical Office <u>OR</u> <input type="checkbox"/> Other: _____	
	Refills Shipped to: <input type="checkbox"/> Patient <u>OR</u> <input type="checkbox"/> Medical Office <u>OR</u> <input type="checkbox"/> Other: _____	
Diagnosis (ICD-10):		
<input type="checkbox"/> D80.0 Congenital Hypogammaglobulinemia	<input type="checkbox"/> D81.9 SCID (Unspecified)	<input type="checkbox"/> D83.9 Common Variable Immunodeficiency
<input type="checkbox"/> G35 MS (Relapse Remitting)	<input type="checkbox"/> G61.0 GBS	<input type="checkbox"/> G61.81 CIDP
<input type="checkbox"/> G61.89 MMN	<input type="checkbox"/> G70.00 MG without acute exacerbation	<input type="checkbox"/> G70.01 MG with acute exacerbation
<input type="checkbox"/> M33.20 Polymyositis	<input type="checkbox"/> M33.90 Dermatomyositis	<input type="checkbox"/> Other: _____
Patient Clinical Information	Weight: _____ lb/kg	Height: _____ in/cm
Allergies: _____		
Lab Orders: _____		
Nursing: <input type="checkbox"/> Please arrange for nursing administration <input type="checkbox"/> Patient may be taught to self-infuse		

5 PRESCRIPTION INFORMATION					
Medication	Route	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Immune Globulin Please write name of product	<input type="checkbox"/> SC <input type="checkbox"/> IV <input type="checkbox"/> IM	_____ grams _____ mg/kg		<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Normal Saline	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> Before and after infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Heparin 10 units/mL <input type="checkbox"/> Heparin 100 units/mL	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> After infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> _____	<input type="checkbox"/> Before and after infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 325 mg <input type="checkbox"/> 650 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> 1 gm	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> _____	<input type="checkbox"/> With each infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> IM <input type="checkbox"/> SQ	<input type="checkbox"/> Adult 1:1000, 0.3mL (>30kg/>66lbs) <input type="checkbox"/> Peds 1:2000, 0.3mL (15-30 kg/33-66 lbs)	<input type="checkbox"/> PRN Anaphylaxis <input type="checkbox"/> Repeating Dose: _____	<input type="checkbox"/> Once <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____					
Vascular Access Method	<input type="checkbox"/> Peripheral <input type="checkbox"/> Central <input type="checkbox"/> Other: _____				

Ancillary supplies and kits provided as needed for administration.

6	
STAMP SIGNATURE NOT ALLOWED	PRESCRIBER SIGNATURE REQUIRED
X PRODUCT SUBSTITUTION PERMITTED	X DISPENSE AS WRITTEN, NO SUBSTITUTION
Date	Date
Interchange is mandated unless the prescriber indicates "No Substitution" in accordance with the law	

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