

**IGIV and General Immune Disorders
Enrollment Form**

SUPERIOR BIOLOGICS
 Fax Referral To: 914-747-1170
 Phone: 855-747-1150



Date: _____

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)
- G61.8 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: _____

Medication	Dose	Directions
<p style="text-align: center;">Intravenous</p> <input type="checkbox"/> Gammagard® Liq. 10% <input type="checkbox"/> Privigen® 10% <input type="checkbox"/> Gamunex-C® 10% <input type="checkbox"/> Octagam® 5% <input type="checkbox"/> Gammaked® 10% <input type="checkbox"/> Octagam® 10% <input type="checkbox"/> Gammagard® S/D <input type="checkbox"/> Other: _____	<p>_____ grams OR _____ gram(s) per kg (Pharmacy to round to nearest vial size) Infuse total dose OVER _____ day(s); Every _____ week(s) for: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Other _____</p>	<p>Infuse total dose of Immunoglobulin intravenously based on manufacturer recommend infusion rate as tolerated. Infuse via: <input type="checkbox"/> Infusion Pump <input type="checkbox"/> Gravity</p>

Medication	Dose	Directions
<p style="text-align: center;">Subcutaneous</p> <input type="checkbox"/> Gammagard® Liq. 10% <input type="checkbox"/> Gamunex-C® 10% <input type="checkbox"/> Gammaked® 10% <input type="checkbox"/> Hizentra® 20% <input type="checkbox"/> HyQvia® 10%	<p>_____ grams OR _____ gram(s) per kg (Pharmacy to round to nearest vial size) Infuse total dose OVER _____ day(s); Every _____ week(s) for: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Other _____</p>	<p>Infuse total dose of Immunoglobulin subcutaneously in one or more infusion sites via infusion pump based on manufacturer recommend infusion rate as tolerated. Other: _____</p>

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
 LMX-4 Cream – apply topically to insertion site as needed. #1 tube
 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 _____