

**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)
- G61.82 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
<p><b>Intravenous</b></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"/> Bivigam® <input type="checkbox"/> Gammagard® S/D <input type="checkbox"/> Other: _____ <input type="checkbox"/> Panzyga® 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 intravenously based on manufacturer recommend infusion rate as tolerated.                      Infuse via:  <input type="checkbox"/> Infusion Pump <input type="checkbox"/> Gravity                      Excludes Medicare D</p>

Medication	Dose	Directions
<p><b>Subcutaneous</b></p> <input type="checkbox"/> Gammagard® Liq. 10% <input type="checkbox"/> Xembify® 20% <input type="checkbox"/> Gamunex-C® 10% <input type="checkbox"/> Cutaquig® 16.5% <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>

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