IG and General Immune Disorders Enrollment Form

Date: _____

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

SUPERIOR BIOLOGICS

PATIENT INFORMATION

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

PRESCRIBER INFORMATION

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

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
☐ 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 IG ☐ Yes ☐ No Line Access: ☐ PIV ☐ PICC ☐ PORT

Medication	Dose	Directions
Intravenous ☐ **IVIg** _____ ☐ **Pharmacy Recommendation**	_____ 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: ☐ Gravity ☐ Infusion Pump Excludes Medicare D
Medication	**Dose**	**Directions**
Subcutaneous ☐ **SCIg** _____ ☐ **Pharmacy Recommendation**	_____ 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 (recommended)

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

IV Access Flush Order:
NaCl 0.9% 5-10ml IV before and after infusion
Heparin 10 Units/ml 5ml after infusion for PICC/Midline
Heparin 10 Units/ml 3ml after infusion for PIV
Heparin 100 Units/ml 5ml IV after infusion for PORT
All infusion supplies necessary to administer the medication

Anaphylaxis Orders and Medications

Diphenhydramine Administer 25 mg slow IV/IM may repeat x1 ***Dispense****: 1 x 50 mg vial*

Epinephrine Autoinjector ☐ Administer 0.15mg (1:2000) IM (< 30 Kg)
☐ Administer 0.3mg (1:1000) IM (≥ 30 Kg)
Dispense: 1 package (2 pens)

Sodium Chloride 0.9% *Use to maintain IV line, prevent or treat hypotension in case of anaphylaxis*
Dispense*:* QS

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

_____ _____ _____ _____
Dispense as Written Date Substitution Allowed Date