


IG 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: _____ Date of Birth: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	PRESCRIBER INFORMATION Prescriber Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ DEA#: _____ Contact Person: _____ NPI#: _____
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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 <input type="checkbox"/> G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) <input type="checkbox"/> G61.82 Multifocal Motor Neuropathy (MMN) <input type="checkbox"/> G61.0 Guillain-Barre <input type="checkbox"/> G25.82 Stiff-Person Syndrome <input type="checkbox"/> G35 Multiple Sclerosis <input type="checkbox"/> G70.01 Myasthenia Gravis w/Exacerbation <input type="checkbox"/> Other: _____	Immunological <input type="checkbox"/> Primary Immune Deficiency – <i>Please specify ICD-10 Code:</i> _____ <input type="checkbox"/> D80.9 Deficiency of Humoral Immunity <input type="checkbox"/> D83.9 Common Variable Immunodeficiency <input type="checkbox"/> D89.9 Immune Mechanism Disorder <input type="checkbox"/> D81.9 Immune Deficiency NOS <input type="checkbox"/> D69.3 Idiopathic Thrombocytopenia <input type="checkbox"/> D80.1 Hypogammaglobulinemia <input type="checkbox"/> Other: _____
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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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Line Access: <input type="checkbox"/> PIV <input type="checkbox"/> PICC <input type="checkbox"/> PORT				

Medication	Dose	Directions
Intravenous <input type="checkbox"/> IVIg _____ <input type="checkbox"/> Pharmacy Recommendation <input type="checkbox"/> Infuse at home <input type="checkbox"/> Infuse at physician office	_____ grams OR _____ gram(s) per kg <i>(Pharmacy to round to nearest vial size)</i> 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: _____	Infuse total dose of Immunoglobulin intravenously based on manufacturer recommend infusion rate as tolerated. Infuse via: <input type="checkbox"/> Gravity <input type="checkbox"/> Infusion Pump <small>Excludes Medicare D</small>

Medication	Dose	Directions
Subcutaneous <input type="checkbox"/> SC Ig _____ <input type="checkbox"/> Pharmacy Recommendation	_____ grams OR _____ gram(s) per kg <i>(Pharmacy to round to nearest vial size)</i> 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: _____	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: <input type="checkbox"/> Diphenhydramine IV or PO 25 mg or 50 mg <small>Please circle route and dose</small> <input type="checkbox"/> Acetaminophen 325mg or 650 mg <small>Please circle dose</small> <input type="checkbox"/> Ketorolac 30mg Slow IV-Push – 30mg/ml vial #1 per dose <input type="checkbox"/> Other: _____ IV Access Flush 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 PICC/Midline and PRN Heparin 100 units/ml 3-5ml IV after infusion for Port and PRN 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 <input type="checkbox"/> Administer 0.3mg (1:1000) Sub-Q (≥ 30 Kg) <input type="checkbox"/> Administer 0.15mg (1:2000) Sub-Q (< 30 Kg) Dispense: 1 package Sodium Chloride 0.9% Use to maintain IV line, prevent or treat hypotension in case of anaphylaxis Dispense: QS
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By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)			
_____	_____	_____	_____
Dispense as Written	Date	Substitution Allowed	Date

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