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|  | | 625 S Pear Orchard Ridgeland, MS 39157  Phone: 769-233-8484 Fax: 769-233-8051 | | IVIG/ SCIG  Enrollment Form | | |
| **Patient Information** | | | **Prescriber Information** | | | |
| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Prescriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Gender: 🞎 Male 🞎 Female Last 4 of SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Insurance Information** (Please fax a copy of patient’s card including front and back) | | | | | | |
| **Medical Information** (Please attach clinical notes) | | | | | | |
| 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Therapy: 🞎 New 🞎 Reauthorization 🞎 Restart | | | |
| Patient’s Weight: \_\_\_\_\_\_\_\_ lb Height:\_\_\_\_\_\_\_ in | | | Requested Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Prescription Information** | | |  | | | |
| **Medication** | **Dose/ Strength** | | **Directions** | | **Quantity** | **Refills** |
| 🞎 Hizentra | 🞎 \_\_\_\_\_\_\_\_\_ gm  🞎 Convert dose from previous IVIG dose | | 🞎 Infuse SQ every week  🞎 Infuse SQ every other week  🞎 Infuse SQ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 🞎 4 week supply | 12 |
| 🞎 IVIG product not specified  🞎 IVIG Gammagard  🞎 IVIG Gamunex  🞎 IVIG Privigen | 🞎 400 mg/kg  🞎 600 mg/kg  🞎 \_\_\_\_\_\_\_\_\_ mg/kg  🞎 \_\_\_\_\_\_\_\_\_ gm | | 🞎 Infuse IV every 4 weeks  🞎 Infuse IV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 🞎 4 week supply | 12 |
| 🞎 NS 1000ml | 🞎 \_\_\_\_\_\_\_\_\_\_\_\_ | | One time bolus after IVIG infusion | | 🞎 4 week supply | 12 |
| 🞎 Premedicate with Benadryl 50mg po and Tylenol 650mg po 30 minutes prior to each dose. | | | | | | |
| Infuse at a rate recommended per manufacturers suggested rate as tolerated. | | | | | | |
| For IVIG infusions, check vital signs prior to the beginning of the infusion, then every 15 minutes x 2, then every 30 minutes x 2, then every hour until infusion is complete. Check vital signs 30 minutes after completion of infusion. | | | | | | |
| Call physician immediately if any reaction occurs. PRN anaphylactic reaction: Stop infusion and call 911. Administer Epinephrine 0.3mg SC or IM, may repeat if needed. Administer Diphenhydramine 50 mg IV or IM. | | | | | | |
| 🞎 Lab Orders: IgG trough prior to 3rd dose; IgG trough, CBC w diff and CMP every 6 months  🞎 Lab Orders: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \* Please fax lab results to Health Care Medical Infusion Specialties at 769-233-8051 | | | | | | |
|  | | | | | | |
| Prescriber’s Signature: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Product Substitution Permitted Date Dispense as Written Date | | | | | | |
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Version 1