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|   | 625 S Pear Orchard Ridgeland, MS 39157Phone: 769-233-8484 Fax: 769-233-8051 | IVIG/ SCIGEnrollment 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 |
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| Prescriber’s Signature: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Product Substitution Permitted Date Dispense as Written Date  |
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