ENVISIONSPECIALTY

Immune Globulin Enrollment Form

Phone: 877-437-9012 Fax: 877-309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: ______
Date of Birth: ______ Sex: M or F Caregiver: ______
Address: ______
City: ______ State: ______ Zip: ______
Home Phone: ______ Work Phone: ______
Cell Phone: ______ E-mail: ______
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: ______
Insurance Company Phone: ______
Policy holder: ______
Policy holder Employer: ______
Relationship to Patient: ______
ID# ______ Group# ______
RxBIN: ______ RxPCN: ______

Prescriber Information

Practice/ Organization Name: ______
Prescriber Name: ______
Address: ______
City: ______ State: ______ Zip: ______
Phone#: ______ Fax#: ______
DEA# ______ NPI# ______
License#: ______ Medicaid UPIN#: ______
Physician Specialty: ______

Date Shipment Needed: ______
Ship to: ☐ **Patient** ☐ **Prescriber** ☐ **Other:** ______
Shipment Address: ______ Attn: ______
City: ______ State: ______ Zip: ______
If shipped to the prescriber's office,Prescriber accepts on behalf of patient for administration in office.

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Clinical Information and Prescription

Primary Diagnosis (ICD10): ☐ _ _ _ . _ _ Description: ______
Secondary Diagnosis (ICD10): ☐ _ _ _ . _ _ Description: ______
Height: ______ inches/cm Weight: ______ lb/kg Date of Measurement: ___/___/______
Allergies: ______
Which antibody is deficient? ☐ IgG ☐ IgA ☐ IgM
If diagnosis of CIDP: 1. Has a Baseline neurological exam been provided? ☐Yes ☐No
2. Does patient have weakness in all 4 limbs accompanied by numbness, impaired proprioception, and ataxia? ☐Yes ☐No
Has the patient tried and failed prophylactic antibiotics prior to immune globulin? ☐ Yes ☐ No
Current Medications: ______
Vascular Access: ☐ Peripheral IV ☐ Port-a-cath ☐ PIC ☐ Central line ☐ Other: ______
Administration by: ☐ Patient ☐ Caregiver ☐ Nursing Agency ☐ Other: ______
Agency nurse to visit home for injection: ☐ No ☐ Yes: Agency Name / Phone: ______
Date of First/Next Injection: ___/___/______ **Date of Last Injection:** ___/___/______

☐ **IVIg lyophilized -No brand preference**
☐ **IVIg lyophilized** –Brand Preferred: ______

☐ **IVIg / SCIg non-lyophilized -No brand preference**
☐ **IVIg / SCIg non-lyophilized** -Brand Preferred: ______

Route of Administration: ☐ IV ☐ SC ☐ IM
Dose: ______ grams per dose x ______ days x ______ weeks
Additional Directions: ______
Total Quantity per Dispense: ______
Flush Protocol: ______
Ancillary medications:

Drug	Strength	Directions	Quantity	Refills
Diphenhydramine				
Acetaminophen				
Epinephrine				

Supplies requested: ______

Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 mos ☐ 1 yr ☐ Other: ______

Prescriber Signature: *X* ______ Date: ___/___/___