



Whole Health Pharmacy

IVIG/SCIG Enrollment Form

Fax: 949-340-8008

Phone: 949-305-0788

Urgent Request

Rep: _____

PATIENT INFORMATION

Patient Name:		<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date:	
Date of Birth:		Height:		Weight:	<input type="checkbox"/> kg <input type="checkbox"/> lbs
Phone:		Mobile Phone:		Email:	
First Dose of IVIG/SCIG	<input type="checkbox"/> YES <input type="checkbox"/> No	Prior IG products tried?			

PRIMARY DIAGNOSIS INFORMATION (ICD 10 diagnosis codes):

Primary ICD-10 Code for IG Diagnosis:					
Route of administration: <input type="checkbox"/> IVIG <input type="checkbox"/> SCIG					
Preferred IVIG Brand: <input type="checkbox"/> Pharmacist to determine		<input type="checkbox"/> Gammagard 5% <input type="checkbox"/> Gammagard 10% <input type="checkbox"/> Gammaked 10% <input type="checkbox"/> Gamunex-C 10% <input type="checkbox"/> Octagam 5% <input type="checkbox"/> Octagam 10% <input type="checkbox"/> Panzyga 10% <input type="checkbox"/> Privigen 10%			
Preferred SCIG Brand <input type="checkbox"/> Pharmacist to determine		<input type="checkbox"/> Hizentra 20% <input type="checkbox"/> Xembify 20%			

IMMUNE GLOBULIN INFORMATION:

Immune Globulin Product	Dose	Frequency	Quantity	Refills

Pre-treatment Information: Nurse to administer the indicated medications 30 -60 minutes prior to IG infusion

Acetaminophen 650 mg PO Diphenhydramine: 25 mg PO **OR** 50 mg PO Diphenhydramine: 25 mg IV push **OR** 50 mg IV push
 Hydrocortisone 100 mg slow IV push Methylprednisolone 125 mg slow IV Push Other _____

ANAPHYLAXIS ORDER INFORMATION

Adult (>30kg) <input type="checkbox"/> Epinephrine 1:1000 (0.3mg) PRN for anaphylactic reaction <input type="checkbox"/> Diphenhydramine 50mg RN to give IV or IM in case of mild allergic reaction <input type="checkbox"/> Other:	Pediatric (15 – 30kg) <input type="checkbox"/> Epinephrine 1:1000 (0.15mg) PRN for anaphylactic reaction <input type="checkbox"/> Diphenhydramine_____mg, usual dose 1-2 mg/kg (up to 50mg), RN to give IV or IM in case of mild allergic reaction <input type="checkbox"/> Other:
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DELIVERY INSTRUCTIONS:

<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Other:	Date Medication Needed:
<input type="checkbox"/> Patient's Home	Address:	
	City/State/Zip:	

PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name:	Office Contact:	
Phone:	Fax:	Specialty:
Address:	City/State/Zip:	
NPI#:	DEA#:	License#:

PLEASE ALSO PROVIDE THE FOLLOWING CLINICAL INFORMATION TO ASSIST WITH THE PRIOR AUTHORIZATION PROCESS:

Immune-deficiency diagnosis: · Antibiotic use history · Chart Notes documented diagnosis · Qualitative/quantitative serum IG levels	Neurological diagnosis: · Chart Notes documented diagnosis · Nerve conduction tests
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***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature: _____ Date: _____

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