

# IMMUNE GLOBULIN (IVIG/SCIG) ENROLLMENT FORM



Please fax this completed sheet along with the following documents for an **EASIER** and more **EFFICIENT** referral process.

**\*Coverage criteria may vary by payer.**

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|--|--|
| <input type="checkbox"/> PATIENT DEMOGRAPHIC SHEET             | <input type="checkbox"/> HISTORY and PHYSICAL (H&P) & CLINICAL NOTES (supporting Dx) – |
| <input type="checkbox"/> COPY OF INSURANCE CARD (front & back) | (within past 6 months) *H&P to include documented infection history/treatment          |
| <input type="checkbox"/> CURRENT MEDICATION LIST               | <input type="checkbox"/> CURRENT LABS – (within last 3 months)                         |

## PATIENT INFORMATION

PATIENT NAME (First, Last, MI)			
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DOB	SOCIAL SECURITY #	
ADDRESS	CITY	STATE	ZIP
PRIMARY PHONE #	ALTERNATE PHONE #	EMAIL ADDRESS	

## CLINICAL INFORMATION

HEIGHT (INCHES)	WEIGHT <input type="checkbox"/> lbs. <input type="checkbox"/> kg	ALLERGIES
PRIMARY DIAGNOSIS - ICD-10 (Specific diagnosis required)		
HAS PATIENT RECEIVED Ig PRODUCT BEFORE? <input type="checkbox"/> Yes <input type="checkbox"/> No	PRIOR Ig PRODUCTS USED and LAST INFUSION DATE?	
ADVERSE REACTION WITH PREVIOUS Ig PRODUCTS? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF SO, WHAT BRAND CAUSED THE REACTION?	

## PRESCRIPTION INFORMATION

ADMINISTER: <input type="checkbox"/> Intravenous (IVIG) <input type="checkbox"/> Subcutaneous (SCIG)	VASCULAR ACCESS: <input type="checkbox"/> PERIPHERAL <input type="checkbox"/> MIDLINE <input type="checkbox"/> PICC <input type="checkbox"/> CVC <input type="checkbox"/> PORT
DOSE (*Dose will be rounded to the nearest whole vial size) LOADING: _____ g/kg X _____ days MAINTENANCE: _____ g/kg X _____ days every _____ weeks	DIRECTIONS Rate Protocol: Titrate initial and maintenance infusions per manufacturer's product labeling. Rates will be individualized for each patient based on tolerability.
QUANTITY/REFILLS: Refill x 1 year unless otherwise noted. <input type="checkbox"/> OTHER:	
PRE-TREATMENT – to be given 30 minutes prior to infusion (Strike through if not required) > Cetirizine 10 mg tab – take 1 tablet by mouth > Acetaminophen 500 mg tab - take 2 tablets by mouth <input type="checkbox"/> Other:	ADVERSE REACTION MEDICATIONS > Epinephrine 1:1000, 1 ml ampule #2 > Diphenhydramine 50mg/1ml vial #1 <input type="checkbox"/> Other: *If reaction occurs, RN will call EMS if necessary & notify prescriber
HYDRATION – PRE-TREATMENT Medication: <input type="checkbox"/> 0.9% Normal Saline _____ ml infused over _____ minutes <input type="checkbox"/> D5W _____ ml infused over _____ minutes Timing: <input type="checkbox"/> Pre-IG Infusion _____ minutes before <input type="checkbox"/> Post-IG infusion <input type="checkbox"/> To be completed during the IVIG infusion	PRN ORDERS <input type="checkbox"/> Ondansetron 4 mg slow IVP as premed for infusion induced nausea <input type="checkbox"/> Other:
LAB ORDERS: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> IgG Frequency: _____ <input type="checkbox"/> Other:	
ADMINISTRATION: Infusion will be administered per Red River Infusion policy and protocols. Nursing: Skilled Nursing visit as need to establish venous access, administer medication, and assess general status and response to therapy.	SUPPLIES: Dispense ambulatory pump and all ancillary supplies necessary to administer home infusion therapy.

## PRESCRIBER INFORMATION

PHYSICIAN NAME (First and Last)	IF NP OR PA – Under direction of which Doctor?
ADDRESS (Include Suite Number if applicable)	CITY STATE ZIP
PHONE FAX	NPI # LICENSE #
OFFICE CONTACT AND TITLE	EMAIL (For Updates)
* PRESCRIBER'S SIGNATURE (Physician attests this is his/her legal signature. NO STAMPS)	DATE

**Please fax your Enrollment Form to: 833-439-0587**

\*By signing this enrollment form, you are agreeing to utilize our services and authorize Red River Infusion Pharmacy and its employees to act as your pre-authorization agent when communicating with medical and prescription insurance companies. The information contained in this facsimile message is privileged and confidential information intended for the use of the addressee listed above. If you are neither the intended recipient or the employee or agent responsible for delivering this information to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or the taking of any action in reliance on the contents of this transmitted information is strictly prohibited. If you have received this transmitted information in error, please immediately notify us at (903) 792-2753 to arrange for the return of documents to us.