IMMUNE GLOBULIN (IVIG/SCIG) ENROLLMENT FORM

RED RIVER Rx
INFUSION PHARMACY

Please fax this completed sheet along with the following documents for an **EASIER** and more **EFFICIENT** referral process.
Coverage criteria may vary by payer.

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

PATIENT INFORMATION

PATIENT NAME (First, Last, MI)

SEX ☐ **MALE** ☐ **FEMALE** | **DOB** | **SOCIAL SECURITY #**

ADDRESS | **CITY** | **STATE** | **ZIP**

PRIMARY PHONE # | **ALTERNATE PHONE #** | **EMAIL ADDRESS**

CLINICAL INFORMATION

HEIGHT (INCHES) | **WEIGHT** ☐ **lbs.** ☐ **kg** | **ALLERGIES**

PRIMARY DIAGNOSIS - ICD-10 **(Specific diagnosis required)**

HAS PATIENT RECEIVED Ig PRODUCT BEFORE? ☐ **Yes** ☐ **No** | **PRIOR Ig PRODUCTS USED and LAST INFUSION DATE?**

ADVERSE REACTION WITH PREVIOUS Ig PRODUCTS? ☐ **Yes** ☐ **No** | **IF SO, WHAT BRAND CAUSED THE REACTION?**

PRESCRIPTION INFORMATION

ADMINISTER: ☐ **Intravenous (IVIG)** ☐ **Subcutaneous (SCIG)** | **VASCULAR ACCESS:** ☐ **PERIPHERAL** ☐ **MIDLINE** ☐ **PICC** ☐ **CVC** ☐ **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. ☐ **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

☐ Other:

ADVERSE REACTION MEDICATIONS

- Epinephrine 1:1000, 1 ml ampule #2
- Diphenhydramine 50mg/1ml vial #1

☐ Other:

*If reaction occurs, RN will call EMS if necessary & notify prescriber

HYDRATION – PRE-TREATMENT

Medication: ☐ 0.9% Normal Saline _____ ml infused over _____ minutes

☐ D5W _____ ml infused over _____ minutes

Timing: ☐ Pre-IG Infusion _____ minutes before ☐ Post-IG infusion

☐ To be completed during the IVIG infusion

PRN ORDERS

☐ Ondansetron 4 mg slow IVP as premed for infusion induced nausea

☐ Other:

LAB ORDERS: ☐ **CBC** ☐ **CMP** ☐ **IgG** **Frequency:** ☐ **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