

**IG and General Immune Disorders
Enrollment Form**

Y Medical Associates
Fax Referral To: 855-838-0623
Phone: 800-447-7558



Date: _____

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Date of Birth: _____
 Gender: M F

PRESCRIBER INFORMATION

Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Fax: _____
 DEA#: _____
 Contact Person: _____ NPI#: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card)

Primary Insurance: _____ ID#: _____ Group: _____
 Secondary Insurance: _____ ID#: _____ Group: _____
 Prescription Card: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

DIAGNOSIS (ICD-10) Neurological

- G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- G61.82 Multifocal Motor Neuropathy (MMN)
- G61.0 Guillain-Barre G25.82 Stiff-Person Syndrome
- G35 Multiple Sclerosis
- G70.01 Myasthenia Gravis w/Exacerbation
- Other: _____

Immunological

- Primary Immune Deficiency – *Please specify ICD-10 Code:* _____
- D80.9 Deficiency of Humoral Immunity
- D83.9 Common Variable Immunodeficiency
- D89.9 Immune Mechanism Disorder D81.9 Immune Deficiency NOS
- D69.3 Idiopathic Thrombocytopenia D80.1 Hypogammaglobulinemia
- Other: _____

CLINICAL INFORMATION (Please attach all clinical information, lab results, and other medical history documents)

Patient Weight: _____ Kg/Lbs Height: _____ Inches/CM Allergies: _____
 Has patient previously received IG Yes No Line Access: PIV PICC PORT

Medication	Dose	Directions
<p style="text-align: center;">Intravenous</p> <input type="checkbox"/> IVIg _____ <input type="checkbox"/> Pharmacy Recommendation	<p>_____ grams OR _____ gram(s) per kg (Pharmacy to round to nearest vial size) Infuse total dose OVER _____ day(s); Every _____ week(s) for:</p> <p><input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Other: _____</p>	<p>Infuse total dose of Immunoglobulin intravenously based on manufacturer recommend infusion rate as tolerated. Infuse via: <input type="checkbox"/> Gravity <input type="checkbox"/> Infusion Pump <small>Excludes Medicare D</small></p>

Medication	Dose	Directions
<p style="text-align: center;">Subcutaneous</p> <input type="checkbox"/> SCIg _____ <input type="checkbox"/> Pharmacy Recommendation	<p>_____ grams OR _____ gram(s) per kg (Pharmacy to round to nearest vial size) Infuse total dose OVER _____ day(s); Every _____ week(s) for:</p> <p><input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Other: _____</p>	<p>Infuse total dose of Immunoglobulin subcutaneously in one or more infusion sites via infusion pump based on manufacturer recommend infusion rate as tolerated. Other: _____</p>

- Labs baseline and then every 6 months: BUN/Creatinine (recommended)
- Premedication** to be given 30 minutes prior to infusion:
 - Diphenhydramine IV or PO 25 mg or 50 mg
Please circle route and dose
 - Acetaminophen 325mg or 650 mg
Please circle dose
 - Ketorolac 30mg Slow IV-Push – 30mg/ml vial #1 per dose
 - Other: _____

IV Access Flush Order:
 NaCl 0.9% 5-10ml IV before and after infusion
 Heparin 10 Units/ml 5ml after infusion for PICC/Midline
 Heparin 10 Units/ml 3ml after infusion for PIV
 Heparin 100 Units/ml 5ml IV after infusion for PORT
 All infusion supplies necessary to administer the medication

Anaphylaxis Orders and Medications

Diphenhydramine Administer 25 mg slow IV/IM may repeat x1
Dispense: 1 x 50 mg vial

Epinephrine Administer 0.15mg (1:2000) Sub-Q (< 30 Kg)
 Administer 0.3mg (1:1000) Sub-Q (≥ 30 Kg)
Dispense: 1 package

Sodium Chloride 0.9% Use to maintain IV line, prevent or treat hypotension
in case of anaphylaxis
Dispense: QS

By signing below, I certify that above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written _____ Date _____ Substitution Allowed _____ Date _____