

**IGIV and General Immune Disorders
Enrollment Form**

Homotech Advanced Therapies
Fax Referral To: 855-884-9283
Phone: 855-494-3121



Date: _____

PATIENT INFORMATION

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

PRESCRIBER INFORMATION

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

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)
- G61.8 Multifocal Motor Neuropathy (MMN)
- G61.0 Guillian-Barre G25.82 Stiff-Person Syndrome
- G35 Multiple Sclerosis M33.20 Polymyositis
- 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 IVIG Yes No Line Access: PIV PICC PORT Needs by Date: _____

Medication

Dose

Directions

Intravenous

- Gammagard® Liq. 10% Bivigam® 10%
- Gamunex-C® 10% Flebogamma® 10%
- Gammaked® 10% Flebogamma® 5%
- Privigen® 10% Octagam® 5%
- Gammplex® 5% Octagam® 10%
- Gammagard® S/D Other: _____

_____ grams OR _____ gram(s) per kg
 (Pharmacy to round to nearest vial size)
 Infuse total dose OVER _____ day(s); Every
 _____ week(s) for:

- 1 month 3 months 6 months 12 months
- Other _____

Infuse total dose of Immunoglobulin intravenously based on manufacturer recommend infusion rate as tolerated. Infuse via:

- Infusion Pump Gravity

Medication

Dose

Directions

Subcutaneous

- Gammagard® Liq. 10%
- Gamunex-C® 10%
- Gammaked® 10%
- Hizentra® 20%
- HyQvia® 10%

_____ grams OR _____ gram(s) per kg
 (Pharmacy to round to nearest vial size)
 Infuse total dose OVER _____ day(s); Every
 _____ week(s) for:

- 1 month 3 months 6 months 12 months
- Other _____

Infuse total dose of Immunoglobulin subcutaneously in one or more infusion sites via infusion pump based on manufacturer recommend infusion rate as tolerated.

Other: _____

Premedication to be given 30 minutes prior to infusion:

- Diphenhydramine 25-50 mg po – 25mg #2 per dose
- Diphenhydramine 25-50 Slow IV-Push – 50mg vial #1 per dose
- Acetaminophen 325-650 mg po – 325mg #2 per dose
- Ketorolac 30mg Slow IV-Push – 30mg/ml vial #1 per dose
- LMX-4 Cream – apply topically to insertion site as needed. #1 tube
- Other: _____

IV Access Flush Order / EpiPen® Order: (Infusion supplies per pharmacy protocol)

- NaCl 0.9% 5-10ml IV before and after infusion
- Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN
- Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN
- All infusion supplies necessary to administer the medication
- EpiPen® 0.3mg auto-injector for severe anaphylactic reaction for patient weighing ≥ 30kg. EpiPen Jr.® 0.15mg for patients weighing under 30kg

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

Dispense as Written

Date

Substitution Allowed

Date