

## Immune Globulin (IVIG) Enrollment Form

### Patient Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone (daytime) \_\_\_\_\_ Phone (cell) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

### Physician Information

Physician Name \_\_\_\_\_ Contact Person \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Physician's DEA Number \_\_\_\_\_ Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

### Statement of Medical Necessity ICD-9 code and document date diagnosis was made:

- |  |  |
|--|--|
| <input type="checkbox"/> <b>204.10</b> B cell chronic lymphocytic leukemia (CLL) | <input type="checkbox"/> <b>287.31</b> Idiopathic thrombocytopenia purpura (ITP)               |
| <input type="checkbox"/> <b>279.00</b> Deficiency of humoral immunity            | <input type="checkbox"/> <b>357.0</b> Chronic inflammatory demyelinating polyneuropathy (CIDP) |
| <input type="checkbox"/> <b>279.03</b> Selective deficiency of IgG               | <input type="checkbox"/> <b>446.1</b> Kawasaki disease   |
| <input type="checkbox"/> <b>279.04</b> Congenital hypogammaglobulinemia (XLA)    | <input type="checkbox"/> <b>710.3</b> Dermatomyositis  |
| <input type="checkbox"/> <b>279.06</b> Common variable immune deficiency (CVID)  | <input type="checkbox"/> <b>710.4</b> Polymyositis   |
| <input type="checkbox"/> <b>279.12</b> Wiskott-Aldrich syndrome                  | <input type="checkbox"/> <b>996.85</b> BMT complication-GVHD                                   |
| <input type="checkbox"/> <b>279.2</b> Combined immunodeficiency (including SCID) | <input type="checkbox"/> <b>Other:</b> ICD-9 Code: _____ Description: _____                    |

### Pertinent Medical History

Patient weight: \_\_\_\_\_ lb. \_\_\_\_\_ kg Allergies: \_\_\_\_\_  
Patient has venous access:  No  Yes → type: \_\_\_\_\_ Lab tests needed: BMP, IgG Quantitative and IgG Subclasses

### Primary Insurance Information Secondary Insurance Information Pharmacy Insurance Information

Insurance Company _____	Insurance Company _____	Insurance Company _____
Cardholder Name _____ SSN _____	Cardholder Name _____ SSN _____	Member ID _____
Group / Policy Number _____	Group / Policy Number _____	BIN Number _____ Group Number _____

### Prescription Orders

#### Immune Globulin (Intravenous)

Infusion supplies & diluents:  NS  D5W  Heparin 100u/ml flush  
Dose: \_\_\_\_\_ grams or \_\_\_\_\_ mg/kg PreMeds:  Benadryl 25 mg IV push  Benadryl 50 mg IV push  
Frequency: Every \_\_\_\_\_ weeks PreMeds:  Acetaminophen 650 mg PO  SoluMedrol 40 mg IV  
Sig: Infuse \_\_\_\_\_ grams over \_\_\_\_\_ hours as directed. PreMeds Refills: Refill \_\_\_\_\_ times  
IVIG Refill:  12 months Refill \_\_\_\_\_ times  
Allergies: \_\_\_\_\_  
Additional orders: \_\_\_\_\_

### Physician Signature

Date \_\_\_\_\_

Fax IVIG enrollment form to (214) 887-0436.

Insurance/ Clearance questions call (214) 276-5642 or e-mail [mike.ellis@ntisp.org](mailto:mike.ellis@ntisp.org). Pharmacy / Clinical call (214) 276-5623. Include the following documents when faxing the enrollment form: patient's insurance card(s) (front and back), Pharmacy Benefit Card, lab work, letter of medical necessity and any other documentation supporting the use of IVIG.

Patient's Preferred Infusion Center Location:  Downtown Dallas  NorthPark