Immune Globulin Enrollment Form

Today's Date: _____

VitalityRx Specialty Pharmacy

Fax Form to 516-464-2520

vitalityrx

Patient Information:

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Sex: ___ M ___ F

Emergency Contact:

Name: _____

Relationship: _____ Phone: _____

Prescriber Information:

Name/Title: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

NPI: _____

Contact Person: _____

Extension (if applicable): _____

Insurance Information (Please attach copies of the front and back of insurance and prescription drug cards):

Primary Insurance: _____ ID#: _____ Group: _____

Secondary Insurance: _____ ID#: _____ Group: _____

Rx Coverage: _____ ID#: _____ BIN: _____ PCN: _____ Grp: _____

Diagnosis Codes (ICD 10):

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

Clinical Information: (Please attach lab results, medical history documents, and other relevant clinical information)

Weight: _____ kg / lb Height: _____ cm / in Allergies: _____

Has patient previously received Ig? ☐ No ☐ Yes If yes, which product? _____

Date of last infusion: _____ Next dose due: _____

Has the patient received any live vaccines in the last 9 months? ☐ No ☐ Yes _____

Comorbid Conditions: ☐ Renal Dysfunction ☐ Headache ☐ Diabetes ☐ CHF ☐ Hx DVT/PE ☐ Chronic Infection: _____

Current Medications: _____

IgA Level: _____ IgG Level: _____ CrCl _____ mL/min Date Collected: _____

Prescription Information: (Pharmacy to round to nearest vial size)

IVIG: ☐ Octagam ☐ Panzyga ☐ Gamunex-C ☐ Gammaked ☐ GammaGard Liquid ☐ GammaGard S/D ☐ Pharmacy Choice (Pharmacist to choose product)

Dose: ☐ _____ grams ☐ 0.4 g/kg ☐ 1 g/kg ☐ Other weight-based dose: _____ g/kg

Frequency: ☐ Administer total dose over _____ days every _____ weeks for _____ months ☐ Once

Directions: ☐ Infuse per manufacturer's instructions ☐ Over _____ hours ☐ Max rate _____ mL/hr ☐ Other: _____

SCIG: ☐ HyQvia ☐ Hizentra ☐ Cuvitru ☐ Xembify ☐ GammaGard Liquid ☐ Gamunex-C ☐ Gammaked ☐ Pharmacy Choice (Pharmacist to choose product)

Dose: ☐ _____ mg/kg ☐ _____ mg (flat dose) ☐ Other: _____

Frequency: Administer total dose over _____ days every _____ weeks for _____ months

Quantity: ☐ 1 month supply on selected medications ☐ Refill for _____ months ☐ Other: _____

Site of care: ☐ Home Infusion ☐ Prescriber's Office ☐ Infusion Suite _____

Needs by date: _____ Deliver to: _____

Are there any functional limitations or mental limitations (reasoning, judgment, memory, etc.) that can hinder access to therapy or affect compliance? ☐ No ☐ Yes: _____

Are there any limitations identified in the patient's social determinants of health (living situation, transportation, access to food, etc.)? ☐ No ☐ Yes: _____

By signing below, I certify that above therapy is medically necessary.

Dispense as Written: Date: **OR** Substitution Permitted: Date: