InfuCare Rx®

Immune Globulin Neurology Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940
referrals@infucarerx.com
www.infucarerx.health

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION

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

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: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

☐ G13.0 Paraneoplastic Syndrome
☐ G25.82 Stiff-Person Syndrome
☐ M33.10 Dermatomyositis
☐ M33.22 Polymyositis
☐ G35.A Relapsing-remitting multiple sclerosis
☐ G35.B0 Primary progressive multiple sclerosis, unspecified
☐ G35.B1 Active primary progressive multiple sclerosis
☐ G35.B2 Non-active primary progressive multiple sclerosis
☐ G35.C0 Secondary progressive multiple sclerosis, unspecified
☐ G35.C1 Active secondary progressive multiple sclerosis
☐ G35.C2 Non-active secondary progressive multiple sclerosis
☐ G35.D Multiple sclerosis, unspecified
☐ G61.0 Guillian-Barré Syndrome
☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ G61.82 Multifocal Motor Neuropathy (MMN)
☐ G70.01 Myasthenia Gravis w/Acute Exacerbation
☐ G70.80 Lambert-Eaton Syndrome
☐ Other: _____

PATIENT EVALUATION

Has patient previously received IVIG? ☐ Yes ☐ No
Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
Line Access: ☐ Peripheral ☐ PICC ☐ Port
Delivery Method: ☐ Infusion Pump ☐ Other: _____
Therapy Start Date: _____ Therapy End Date: _____
Injection Training/Home Health RN visit is necessary. ☐ Yes ☐ No
☐ Home ☐ MD Office ☐ Other: _____

☐ Patient demographics, including insurance information.
☐ Labs – Antibody testing results, most recent BUN/SCr and IgA level
☐ H&P
☐ Medications tried and failed: _____
☐ Baseline assessment, including detailed patient symptoms
☐ Please attach original prescription orders

As Appropriate:
☐ Nerve Conduction Study results, including velocities
☐ Biopsy results
☐ Electromyography (EMG) results
☐ CSF studies

☐ Other: _____

PRESCRIPTION INFORMATION

Immune Globulin Prescription (IVIG):

Loading Dose: IVIG _____ gm per kg given over _____ day(s) OR _____ gm daily for _____ day(s)

Maintenance: IVIG _____ gm per kg given over _____ day(s) OR _____ gm daily for _____ day(s)

☐ Repeat course every _____ week(s) x _____ course(s). Refill x 1yr.

Subcutaneous Immune Globulin Prescription (SCIG):

SCIG _____ gm monthly OR _____ gm every _____ weeks. Refill x 1yr.
☐ Pharmacy to select number of infusion sites OR ☐ Administer with _____ needle sites

☐ OK to round to the nearest vial size
☐ +/- 4 days to allow scheduling flexibility

Multiple doses will be administered on consecutive days unless ordered otherwise.
☐ non-consecutive days only

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol
☐ NaCl 0.9% 5mL
☐ NaCl 0.9% 10mL
☐ Heparin 10 units per mL
☐ Heparin 100 units per mL
☐ 250mL 0.9% NaCl for hydration
☐ Other: _____

Premedications & Other Medications
☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol
☐ Acetaminophen _____ mg PO prior to infusion
☐ Diphenhydramine _____ mg PO

Prescriber Signature: _____ **Date:** _____

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