IGIV and General Immune Disorders Enrollment Form	SUPERIOR BIOLOGICS **Fax Referral To: 914-747-1170** **Phone: 914-747-1150**	SUPERIOR BIOLOGICS
Date: _____		

Needs by Date: _____ Ship to ☐ Home ☐ Office ☐ Other: _____

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

Neurological

☐357.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐357.9 Multifocal Motor Neuropathy (MMN)
☐357.0 Guillian-Barre ☐358.01Myasthenia Gravis
☐340 Multiple Sclerosis ☐710.4 Polymyositis
☐Other: _____

Immunological

☐Primary Immune Deficiency
Please specify ICD-9 Code: _____
☐279.0 Deficiency of Humoral Immunity
☐279.06 Common Variable Immunodeficiency
☐279Immune Mechanism Disorder ☐ 279.3 Immune Deficiency NOS
☐287.31 Idiopathic Thrombocytopenia ☐ 446.1 Kawasaki Syndrome
☐Other: _____

PATIENT EVALUATION

- Has patient previously received IVIG ☐ Yes ☐ No
- Patient Weight: _____Kg/Lbs Height: ____Inches/CM
- Allergies: _____
- Line Access: ☐ PIV☐ PICC ☐ PORT ☐ Central
- Delivery Method: ☐ Gravity ☐ Infusion Pump
- Therapy Start Date: _____Length of Therapy: _____
- Nursing Coordination:
  - Pharmacy to coordinate home health nursing visit as necessary:
    ☐ Yes☐ No
  - Home health nursing coordination not necessary. Reason:
    ☐MD Office to administer to Patient
    ☐Home health nursing already coordinated

PRESCRIPTION INFORMATION

Medication		Directions (Route/Frequency/Length of Infusion)	Quantity (Gm)	Refills
☐ Gammagard ☐ Liq ☐ SD	☐ Gamunex-C			
☐ Bivigam	☐ Privigen			
☐ Gammaplex	☐ Octagam			
☐ Gammaked	☐ Gammastan			
☐ HyQvia	☐ Hizentra 20%			
☐ NPlate	☐_____			

Other Medications

Flush Protocol

☐NaCl 0.9% 5-10ml ☐D5W 5-10ml [pre/post infusion & 3-5ml of Heparin 100u/ml] ☐Other: _____

Pre-Medications & Other Meds:

☐Infusion supplies as per protocol
☐EpiPen® ☐Diphenhydramine _____mg ☐PO☐IVP Prior to Infusion ☐Acetaminophen _____mg PO Prior to Infusion

Prescriber Signature: _____ **Date:** _____