Sunrise Rx
POSITIVE PATIENT OUTCOMES

**FAX REFERRAL TO: 1-877-543-9991**
**PHONE: 1-877-519-0588**

# IMMUNE GLOBULIN ENROLLMENT FORM

Date: _____

Date Needed: _____

Administration Location:
☐ Patient Home
☐ Infusion Suite
☐ Other _____

## PATIENT INFORMATION
(Complete the following *or send patient demographic sheet*)

Name: _____
Address: _____
City, State, Zip: _____
Cell Phone: _____
Alternate Phone: _____
Caregiver: _____
Date of Birth: _____ Sex: M - F

## INSURANCE INFORMATION
**Primary Insurance/Prescription Card:**
PLEASE FAX COPY OF INS CARD (front and back if available)
**Secondary Insurance/Prescription Card:**
PLEASE FAX COPY OF INS CARD (front and back if available)

## DIAGNOSIS / ICD 9 CODE
☐ G61.81CIDP
☐ G61.82 MMN
☐ G70.01 MG with Acute Exacerbation
☐ G70.00 MG w/o Acute Exacerbation
☐ M33.20 Polymyositis
☐ M33.90 Dermatomyositis
☐ L10.0 Pemphigus
☐ Other:

## PRESCRIBER INFORMATION

Name: _____
Practice Name: _____
Address: _____
City, State, Zip: _____
Office Phone: _____
Office Fax: _____
NPI#: _____
Key Office Contact: _____

## CLINICAL INFORMATION

Weight: _____kg or _____lbs.
Height: _____ inches
Vascular Access: ☐ Peripheral ☐ Port ☐ Central
Use Existing Venous Access for IVIG Infusion?: ☐ Yes ☐ No
History of: ☐ Cardiac Disease ☐ Diabetes ☐ Renal Dysfunction
IgA Deficient: ☐ Yes ☐ No
Allergies: _____

## RX INFORMATION

| MEDICATION | STRENGTH & DIRECTIONS FOR USE | QUANTITY | REFILLS |
|---|---|---|---|
| ☐ **Intravenous Immune Globulin**<br>☐ **Subcutaneous Immune Globulin**<br>☐ **Other:** | Dose: _____ grams *OR* _____ grams per kg<br>☐ Repeat dose daily x _____consecutive days total<br>☐ Repeat dose weekly x _____weeks total<br>☐ Repeat dose monthly x _____months total<br>☐ Other frequency<br>Where clinically appropriate, round to the nearest vial size. | | |

## PRE-MEDICATIONS

| MEDICATION | STRENGTH | DIRECTIONS FOR USE | QUANTITY | REFILLS |
|---|---|---|---|---|
| ☐ **Diphenhydramine** | ☐ 25 mg<br>☐ 50 mg | Take one dose by mouth ½ hour prior to administration of IVIG. | | |
| ☐ **Acetaminophen** | ☐ 325 mg<br>☐ 650 mg | Take one dose by mouth ½ hour prior to administration of IVIG. | | |
| ☐ **Sodium Chloride Hydration** | ☐ 0.9% | Hydrate with IV Infusion of _____ ml prior to administration of IVIG. | | |
| ☐ Other: | | | | |

## INFUSION SUPPLIES

| MEDICATION | STRENGTH & DIRECTIONS FOR USE | QUANTITY | REFILLS |
|---|---|---|---|
| ☐ **Sodium Chloride .9% Flush** | Flush line/port with 3-5 ml for PIV and 5-10 ml for central line/port. | | |
| ☐ **Heparin 100 U/ML Flush** | Flush port/central line with 3-5 ml. | | |
| ☐ **Anaphylaxis Kit/Epi Pen** | Inject intramuscularly or subcutaneously into thigh prn anaphylaxis. | | |
| ☐ Other: | | | |

_____
Prescriber Signature (Date)

☒ *I authorize Sunrise Rx staff or its representatives to act as an agent to initiate and execute any insurance company prior authorization or precertification on my behalf.*