



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
<input type="checkbox"/> Intravenous Immune Globulin	Dose: _____ grams *OR* _____ grams per kg		
<input type="checkbox"/> Subcutaneous Immune Globulin	<input type="checkbox"/> Repeat dose daily x _____ consecutive days total		
	<input type="checkbox"/> Repeat dose weekly x _____ weeks total		
	<input type="checkbox"/> Repeat dose monthly x _____ months total		
<input type="checkbox"/> Other:	<input type="checkbox"/> Other frequency		
	Where clinically appropriate, round to the nearest vial size.		

PRE-MEDICATIONS

MEDICATION	STRENGTH	DIRECTIONS FOR USE	QUANTITY	REFILLS
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg	Take one dose by mouth ½ hour prior to administration of IVIG.		
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 325 mg <input type="checkbox"/> 650 mg	Take one dose by mouth ½ hour prior to administration of IVIG.		
<input type="checkbox"/> Sodium Chloride Hydration	<input type="checkbox"/> 0.9%	Hydrate with IV Infusion of _____ ml prior to administration of IVIG.		
<input type="checkbox"/> Other:				

INFUSION SUPPLIES

MEDICATION	STRENGTH & DIRECTIONS FOR USE	QUANTITY	REFILLS
<input type="checkbox"/> Sodium Chloride .9% Flush	Flush line/port with 3-5 ml for PIV and 5-10 ml for central line/port.		
<input type="checkbox"/> Heparin 100 U/ML Flush	Flush port/central line with 3-5 ml.		
<input type="checkbox"/> Anaphylaxis Kit/Epi Pen	Inject intramuscularly or subcutaneously into thigh prn anaphylaxis.		
<input type="checkbox"/> 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.

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