



DOCTOR/PRESCRIBER Immune Globulin Subcutaneous Enrollment Form

1. DOCTOR/PRESCRIBER FILL OUT AND
FAX TO: 1-866-413-4139 or Call: 1-866-413-4138

- Faxes will only be accepted from a doctor's office.
- Class II medications cannot be faxed.

Patient Information New Rx Refill

Name: _____
 Address: _____
 City: _____ ST: _____ Zip: _____
 Date of Birth (mm/dd/yyyy): ____/____/____

Phone #1: _____ Phone #2: _____
 Allergies: _____ No Known Allergies
 Health Conditions: _____
 Expected Start Date: ____/____/____

Statement of Medical Necessity

Patient Weight: _____ lbs kg Primary Diagnosis: _____ ICD9 Code: _____

Current Laboratory Values

Patient is IgA deficient IgA level: _____ mg/dL
 Patient is diabetic Current A1C: _____ %
 Recent IgG trough: _____ mg/dL Date taken: ____/____/____
 Serum Creatinine: _____ mg/dL Date taken: ____/____/____

Prior Therapy

Patient was previously treated with Intravenous Immune Globulin (IVIG)
 Product: _____ Dose: _____ Interval: _____
 Date of last infusion: ____/____/____

Drug Delivery Information If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

In Office Delivery Home Delivery for Self Injection/Administration
 Home Delivery for Home Health Administration Outpatient Clinic
 Other: _____

Contact: _____
 Phone #: _____
 Address: _____

Insurance Information Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: _____
 Insured: _____
 ID #: _____ Group #: _____
 Phone #: _____ Rx Drug Card #: _____
 Rx Bin #: _____ Rx PCN #: _____ Rx Grp #: _____

Secondary: _____
 Insured: _____
 ID #: _____ Group #: _____
 Phone #: _____ Rx Drug Card #: _____
 Rx Bin #: _____ Rx PCN #: _____ Rx Grp #: _____

Doctor/Prescriber Information NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: _____
 Address: _____
 City: _____ ST: _____ Zip: _____

Office Contact: _____
 NPI #: _____ DEA #: _____
 Phone #: _____ Fax #: _____

2. COMPLETE THE FOLLOWING RX FORM -OR- TAPE RX HERE"

Date: ____/____/____	
Rx	
Drug Name/Form/Strength	Directions for Use
<input type="checkbox"/> Vivaglobin®	
<input type="checkbox"/> Hizentra™	
<input type="checkbox"/> Gamunex-C	
<input type="checkbox"/> EpiPen® <input type="checkbox"/> EpiPen Jr®	
Other:	
Quantity: _____ Refills: _____	
Needles Gauge: _____ Inches: ____ Quantity: ____ Refills: ____	Syringes Volume: _____ Inches: ____ Quantity: ____ Refills: ____
X _____ Doctor/Prescriber Signature – Dispense as Written Stamped signatures cannot be accepted	X _____ Doctor/Prescriber Signature – Substitution Permissible Stamped signatures cannot be accepted

Federally approved, generic-equivalent medications will be dispensed for brand-name medications unless otherwise directed by the patient, physician, or health plan.
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