

**IMMUNE GLOBULIN
ENROLLMENT / PRESCRIPTION FORM**

Customer Service Phone 1-800-850-9122

Fax to 1-800-218-3221

PATIENT INFORMATION

Last Name	First Name	MI	ID Number
Home Address	City	State	Zip
Shipping Address (if different from home address)	<input type="checkbox"/> Ship to MD	Home Phone Number ()	Work Phone Number ()

INSURANCE INFORMATION (fill out entirely or fax a copy of patient's Insurance card, both sides)

Primary Insurance	Secondary Insurance
Insured	Insured
Policy Number	Policy Number
Group Number	Group Number

PRIMARY DIAGNOSIS

ICD-9	Diagnosis
042	Human immunodeficiency virus [HIV] disease
204	Lymphoid leukemia, chronic
279.00	Hypogammaglobulinemia
279.03	Other selective immunoglobulin deficiencies (selective deficiency of IgG)
279.04	Congenital hypogammaglobulinemia
279.05	Immunodeficiency with increased IgM
279.06	Common variable immunodeficiency
279.12	Wiskott-Aldrich syndrome
279.2	Combined immunity deficiency
287.32	Evans' Syndrome
287.31	Immune thrombocytopenia purpura
357.0	Acute infective polyneuritis (Guillain-Barre Syndrome)
357.81	Chronic inflammatory demyelinating polyneuritis (including CIDP)
357.9	Unspecified inflammatory and toxic neuropathy (including Multifocal Motor Neuropathy)
358.01	Myasthenia gravis with acute exacerbation
358.1	Myasthenic syndromes in diseases classified elsewhere (Eaton-Lambert Syndrome)
446.1	Acute febrile mucocutaneous lymph node syndrome [MCLS] (Kawasaki disease)
694.4	Pemphigus
694.5	Pemphigoid
694.60	Benign mucous membrane pemphigoid without mention of ocular involvement
694.61	Benign mucous membrane pemphigoid with ocular involvement
694.8	Other specific bullous dermatoses
710.4	Polymyositis
710.3	Dermatomyositis
728.89	Other disorders of muscle, ligament and fascia (including Inclusion Body Myositis)
V42.81	Organ of tissue replaced by transplant; bone marrow
V42.82	Organ of tissue replaced by transplant; peripheral stem cells
	Other specify

MEDICAL INFORMATION

Start Date _____	End Date _____	Next infusion date _____
Height _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Weight _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs	Date of Last measurement _____
Allergies _____	<input type="checkbox"/> NKDA	
Co-morbidities _____	<input type="checkbox"/> See Attached	
Current Medications _____	<input type="checkbox"/> See Attached	

Due to the allocation of IVIG products, not all brands are available at all times.

PRESCRIPTION INFORMATION

<input type="checkbox"/> IVIG lyophilized (powder) (no brand preference)	<input type="checkbox"/> IVIG non-lyophilized (liquid) (no brand preference)
<input type="checkbox"/> Carimune-NF <input type="checkbox"/> Gammagard S/D <input type="checkbox"/> Gammar-P	<input type="checkbox"/> Cytogam <input type="checkbox"/> Flebogamma <input type="checkbox"/> Gammagard
<input type="checkbox"/> Panglobulin-NF <input type="checkbox"/> Polygam S/D	<input type="checkbox"/> Gamunex <input type="checkbox"/> Octagam
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

Directions

Qty _____ Refills _____ BNMN/DAW

PRESCRIBER INFORMATION

Prescriber	Specialty	Office Contact	Phone Number
Address	City	State	Zip
Today's Date	Date Needed	I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge.	NPI _____
		Physician's Signature	DEA _____

Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Saturday delivery requires approval from an Ascend pharmacist.

For refills, please call-in or fax 7 days in advance of next appointment.

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