IMMUNE GLOBULIN ENROLLMENT FORM
Fax to: 844-295-5518

HILL COUNTRY PHARMACY

DATE: _____ **SHIP TO:**
DATE NEEDED: _____ ☐ PATIENT ☐ OFFICE

PHARMACY LOCATION
11233 Shadow Creek Pkwy, Suite 123A
Pearland, TX 77584
Phone: 844.295.5516

PATIENT INFO

NAME: _____ E-MAIL_____ DOB:_____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY_____ STATE_____ ZIP_____

HOME TELEPHONE:_____ MOBILE PHONE:_____ SS#__ __ __ - ___ ___ - ___ ___ ___ ___

INSURANCE INFORMATION **PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)**

CLINICAL INFORMATION

PATIENT EVALUATION

Weight:_____ Height:_____ Allergies:_____ ☐ NKDA ☐ Latex Allergy

Comorbidities: _____

Other Medications: _____

Access/administration: ☐ Peripheral ☐ Central ☐ Port ☐ Subcutaneous ☐ Other: _____

Has patient received immunoglobulin previously? ☐ Yes ☐ No

If yes, please list the product brand and dose: _____

Date of last infusion: _____ Date of next infusion: _____

DIAGNOSIS CODES

- ☐ D69.3 Idiopathic Thrombocytopenic Purpura (ITP)
- ☐ D81.9 Severe combined immunodeficiency (unspecified)
- ☐ D83.9 Common variable immunodeficiency
- ☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy
- ☐ G61.89 Multifocal Motor Neuropathy
- ☐ G35 Multiple Sclerosis (Relapsing Remitting)
- ☐ M33.20 Polymyositis
- ☐ M33.9 Dermatomyositis
- ☐ Other:_____

PRESCRIPTION INFORMATION

PRESCRIPTION INFORMATION- Immune Globulin Products:

- ☐ Carimune® NF
- ☐ Flebogamma® 5%
- ☐ Flebogamma® 10%
- ☐ Gammagard® Liquid 10%
- ☐ Gammagard® S/D
- ☐ Gammaked® 10%
- ☐ Gammaplex® 5%
- ☐ Gamunex-C® 10%
- ☐ Hizentra® 20% (SC admin)
- ☐ Octagam® 5%
- ☐ Octagam® 10%
- ☐ Privigen® 10%
- ☐ IVIG (Pharmacy to determine)

Dose / Directions

Dose: _____ g/kg Total dose: _____ grams

☐ Daily for _____ day (s) every _____ week (s)

☐ Other: _____

_____

Quantity: ☐ 1 month supply ☐ 3 month supply ☐ _____

Refills: ☐ 1 year ☐ _____

Notes: _____

_____

_____

OTHER

DRUG NAME: _____
☐ Strength:_____
☐ Directions: _____
QTY: ☐ _____ **Refills** _____

DRUG NAME: _____
☐ Strength:_____
☐ Directions: _____
QTY: ☐ _____ **Refills** _____

PRESCRIBER INFORMATION

Prescriber's Name: _____ Contact Person:_____

Telephone: _____ Fax:_____ Email:_____

Office Address: _____ City:_____ State: _____ Zip:_____

NPI # : _____ DEA # : _____ UPIN # : _____ Medicaid Provider # : _____

_____ _____ * _____

PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Form: © REF-ImmGlob-E-
Hill Country
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