



IVIG Enrollment Form
 Ph: (877)342-9352 Fax: (877) 542-9352

Patient Name:		Date of Birth:	Social Security #:	
Home Address:		City:	State:	Zip:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone: ()	Work: ()	Cell: ()	
Emergency Contact Name:		Ph #: ()	Relationship:	
Primary Insurance:		Secondary Insurance:		
Policy #:	Group #:	Policy #:	Group #:	
Subscriber:	Date of Birth:	Subscriber:	Date of Birth:	
Phone #:	Employer:	Phone #:	Employer:	
Prescription Drug Card:		ID#:	Phone #:	

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis:
 _____ _____

Medical Assessment:
 Height: _____ Weight: _____ kg /lbs
 Advanced Directives? No Yes History of Diabetes? No Yes
 Kidney or Heart Disease? No Yes Ambulatory? No Yes
 Allergies: _____
 Is Patient currently on any medication? No Yes List: _____

PRESCRIPTION

Medication Order: _____ Dose: _____ Frequency: _____ Duration: _____

Refills:
 Dispensed as written Substitution allowed
 Has 1st Dose Been Given? Yes Date: _____ Time: _____ Place: _____ No Anticipated Start Date: _____

Premedication Orders:
 Anaphylaxis Kit per protocol
 -Mild reaction give Diphenhydramine 50mg(2tabs), slow infusion. If needed give 2 additional tabs (50mg).
 -Moderate reaction give 50mg Diphenhydramine (2tabs) and stop infusion.
 - Severe reaction w/breathing problem give 50mg IV Diphenhydramine; EpiPen; 500ml NaCl 0.9% fluid and call 911.
 Start PIV as required for administration
 Other _____

Physician Signature: _____ Date: _____
 By signing, I certify/recertify that the above therapy, products, and services are medically necessary and that this patient is under my care. I have received the necessary authorization to release the above referenced information and medical and/or patient information relating to this therapy.

Physician: _____
 Practice: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: () _____ Fax: () _____ Contact: _____
 NPI: _____ DEA: _____ Tax ID: _____