elixir
SPECIALTY PHARMACY

Immune Globulin Enrollment Form
Phone: 1-877-437-9012 Fax 1-877-309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: _____
Date of Birth: __/__/____ Sex: M☐ or F☐ SS#_____
Address: _____
City: _____ State: ____☐ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policyholder: _____
Policy holder Employer: _____
Relationship to Patient: _____
ID# _____ Group# _____
RxBIN: _____ RxPCN: _____

Prescriber Information

Practice/ Organization Name: _____
Physician Name: _____
Address: _____
City: _____ State: _____☐ Zip: _____
Phone#: _____ Fax#: _____
DEA# _____ NPI# _____
License#: _____ Medicaid UPIN#: _____
Physician Specialty: _____
Date Shipment Needed: __/___/_____ Attn: _____
Ship to: ☐Patient ☐Prescriber ☐Infusion Clinic
Shipment Address: _____
City: _____ State: _____☐ Zip: _____
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

☐ **SKILLED NURSING** visit to establish venous access, provide patient education related to therapy and disease state, administer medication as prescribed, and assess general status and response to therapy. Frequency based on prescription dose orders.

Clinical Information and Prescription

Diagnosis code: _____ Patients Allergies: _____
Patient Weight: _____ kgs or lbs (*please indicate*) Patient Height: _____ inches or cm. (*please indicate*)
Prior Treatments with duration and reason for discontinuation _____
Adverse reactions with previous IG treatments? _____ If so, what brand of IG? _____

Medication	Strength/Formulation	Directions
☐ Bivigam® 10% ☐ Gammagard® liquid 10% ☐ Gammagard® S/D ☐ 5% ☐ 10% ☐ Gammaked™ 10% ☐ Gammaplex® ☐ 5% ☐ 10% ☐ Gamunex®-C 10% ☐ Hizentra 20% ☐ PFS ☐ SDV ☐ Octagam® ☐ 5% ☐ 10% ☐ Panzyga® 10% ☐ Privigen® 10% ☐ Any brand ☐ Other: _____	Infuse _____ grams OR _____ grams per kg OR _____ mg per kg every _____weeks ☐ Divide total dose over _____ days (where clinically appropriate, round to the nearest vial size) ☐ Quantity: _____ ☐ Refills: _____	**Route:** ☐ SQ ☐ IV **Vascular access**: ☐ Peripheral ☐ Central ☐ Port **Infusion method**: ☐ Gravity ☐ Pump **Rate protocol:** Titrate initial and maintenance infusions per manufacturer's product labeling.

Dose	Directions	Quantity	Refills
☐**Acetaminophen** ☐ 325mg ☐ 500mg ☐ **Diphenhydramine** ☐ 25mg ☐ 50mg	☐ Take _____ mg p.o. 30-60min. prior to inf. and q4-6hr prn. Maximum of 4 doses in 24 hrs. ☐ _____	☐ Qty:	☐ 11 ☐ ___
☐ **Epinephrine** ☐ 0.3mg auto-injector ☐ 0.15mg auto-injector	Inject IM p.r.n anaphylaxis	☐ Qty:	☐ 1 ☐ ___
☐ NaCl 0.9% 10ml flush	Flush line with 10ml, before and after infusion and p.r.n line care.	☐ Qty:	☐ 11 ☐ ___
☐ Heparin 100U/ml 5ml PFS ***for central line patients**	Flush line with 5ml after final saline flush.	☐ Qty:	☐ 11 ☐ ___
☐ Emla cream- lidocaine 2.5% /prilocaine 2.5%	Apply topically to needle insertion site, 30-60 minutes prior to infusion.	☐ Qty:	☐ 11 ☐ ___
☐ Hydration fluid	0.9% NS _____ mL infused over _____ minutes Timing: ____ minutes ☐ pre IG ☐ post IG ☐ during IG	☐ Qty:	☐ 11 ☐ ___
☐Other:	☐ Sig:	☐ Qty:	☐ ___

X _____ Date: _____/_____/_____
Physician Signature (no stamps) For No Substitution allowed, please indicate "DAW" here: _____