elixir
SPECIALTY PHARMACY

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

☐ **New to Therapy**
☐ **Current Therapy**

Customer Information

Customer Name: _____
Date of Birth: _____ Sex: M or F Caregiver:_____
Address: _____
City: _____State:_____Zip:_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail:_____
Please attach copy of front and back of customer's prescription insurance card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder:_____
Policy holder Employer:_____
Relationship to Customer:_____
ID# _____Group#_____
RxBIN: _____RxPCN:_____

Prescriber Information

Practice/ Organization Name: _____
Prescriber Name:_____
Address:_____
City: _____State: _____ Zip: _____
Phone#:_____Fax#:_____
DEA#_____NPI#_____
License#:_____Medicaid UPIN#:_____
Physician Specialty: _____

Date Shipment Needed: _____
Ship to: ☐ **Patient** ☐ **Prescriber** ☐ **Other:**_____
Shipment Address: _____Attn: _____
City: _____State: _____Zip:_____
If shipped to the prescriber's office,Prescriber accepts on behalf of patient for administration in office.

Clinical Information and Prescription

Primary Diagnosis (ICD10): ☐ _ _ _ . _ _ Description: _____
Secondary Diagnosis (ICD10): ☐ _ _ _ . _ _ Description: _____
Height: _____inches/cm Weight:_____ lb/kg Date of Measurement: ___/_____/_____
Allergies: _____
Which antibody is deficient? ☐ IgG ☐ IgA ☐ IgM
If diagnosis of CIDP: 1. Has a Baseline neurological exam been provided? ☐Yes ☐No
2. Does patient have weakness in all 4 limbs accompanied by numbness, impaired proprioception, and ataxia? ☐Yes ☐No
Has the patient tried and failed prophylactic antibiotics prior to immune globulin? ☐ Yes ☐ No
Current Medications: _____
Vascular Access: ☐ Peripheral IV ☐ Port-a-cath ☐ PIC ☐ Central line ☐ Other: _____
Administration by: ☐ Patient ☐ Caregiver ☐ Nursing Agency ☐ Other: _____
Agency nurse to visit home for injection: ☐ No ☐ Yes: Agency Name / Phone: _____
Date of First/Next Injection: ____/____/_____ **Date of Last Injection:** ____/____/_____

☐ **IVIg lyophilized -No brand preference**
☐ **IVIg lyophilized** –Brand Preferred: _____

☐ **IVIg / SCIg non-lyophilized -No brand preference**
☐ **IVIg / SCIg non-lyophilized** -Brand Preferred: _____

Route of Administration: ☐ IV ☐ SC ☐ IM
Dose: _____ grams per dose x _____ days x _____weeks
Additional Directions: _____
Total Quantity per Dispense:_____
Flush Protocol: _____
Ancillary medications:

Drug	Strength	Directions	Quantity	Refills
Diphenhydramine				
Acetaminophen				
Epinephrine				

Supplies requested: _____
_____
Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 mos ☐ 1 yr ☐ Other: _____

Prescriber Signature: *X*_____ Date: _____/_____/_____