IVIG Intake Form (SCIG)

Demographic Information

Last Name:		First Name:		SS#:	
Home Address:			City:	State:	Zip:
DOB:	Height:	Weight:	Allergies:		
Phone (H):		Phone (C):		Phone (W):	

Emergency Contact:_____ Patient's Gender: ☐ Male ☐ Female

Phone (H):_____ Phone (C) _____ Phone (W)_____

Insurance Information

Primary Insurance:		Subscriber Name:
Policy #:	Group #:	PCN:
RX BIN:	Insurance Phone:	
Secondary Insurance:		Subscriber Name:
Policy #:	Group #:	PCN:
RX BIN:	Insurance Phone:	

Medical Necessity Assessment

Primary Diagnosis:	
ICD-9 Code:	
Secondary Diagnosis:	
Use of Previous SCIG Product:	
IgA Level & Date:	IgG Level & Date:
Hct & Date:	Platelets Count & Date:
Additional History:	

Additional Medical History

History of: ☐ Renal Insufficiency ☐ Diabetes ☐ HTN ☐ CHF ☐ Thromboembolic event
☐ Other:_____

Physician Information

MD:	License:	NPI:
Hospital/Clinic:		Phone:
Fax:	Address:	
Office Contact:		Medicaid #:

Referral Phone: 787-704-2025
Referral Fax: 787-704-2027

Patient Name: _____ **Date of Birth:** _____

IVIG to SCIG Conversion Worksheet

Anticipated Start Date:_____

Hizentra (20%) (200mg/mL) _____

How supplied: 5mL (1g); 10 (2g); 20mL (4g) **round doses to next vial size**

Weekly Hizentra SCIG dose (g) = IVIG dose (g) x 1.53 / IVIG weekly interval originally given.

Total weekly # grams Hizentra / 0.20mL = _____ml per week

Gamunex-C (10%) (100mg/mL) _____ **OR** **Gammagard Liquid** (10%) (100mg/mL) _____

How supplied: 10mL (1g); 25mL (2.5g); 50mL (5g) **round doses to next vial size**

Weekly SCIG dose (g) = IVIG dose (g) x 1.37 / IVIG weekly interval originally given

Total weekly # grams Gamunex-C / 0.10mL = _____mL per week

Prescription

Total weekly dose _____grams (_____total mL) _____
(product)

Divide into 1-2-3-4 _____ equal doses over each week

To be infused simultaneously into 1-2-3-4-5 _____ subcutaneous sites using pump over _____ hours

Dispense 4-week supply = _____mL with _____ refills
Dispense in combination of single-use vial sizes to equal total ml prescribed for each dose

Treatment Settings

Initial Treatment Setting: ☐ Physician Office ☐ Home
☐ Began treatment in clinical setting - transition to home

Patient Training: Do you want the Specialty Pharmacy to coordinate infusion nurse training of the patient? ☐ Yes ☐ No

☐ Skilled nursing visit to: train patient/caregiver in SCIG administration, provide education related to disease state/therapy, and assess general status.
(*Typically 3 training visits required 2-4 hours in length each).*

☐ Would you like the SP to contact you regarding nursing notes/pharmacy progress reports on the status of this SCIG patient? ☐ Yes ☐ No

Supplies: Specialty Pharmacy to provide all syringes, needles, ancillary supplies and pump required for the safe and appropriate administration of SCIG.

Ancillary Medications

Specialty Pharmacy to provide the following, including training patient on appropriate usage:

_____ EpiPEN Epinephrine 1:1000,0.3mL, 0.3mg - Use as directed

_____ EpiPEN Jr. Epinephrine 1:2000, 0.3mL, 0.3mg - Use as directed

_____ Emla Cream Apply to SC needle sites as directed - May substitute

I authorize SPS Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature:_____ Date:_____

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