Immunoglobulin Enrollment Form

Parkway SPECIALTY PHARMACY

3502 U.S. Highway 9. Howell. N.J. 07731 | www.**parkwaysp**.com | Email: intake@parkwaysp.com | Phone: 1-866-355-7797 | Fax: 1-888-551-6289

PATIENT INFORMATION

Name:	Date of Birth:	O Male O Female
Address:	City: State:	Zip:
Phone:	Alt Phone:	Email:
SS #:	Primary Language:	Emergency Contact:

PRESCRIBER INFORMATION

Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:	City:	State:	Zip:	Tax ID:
Phone:	Fax:			Office Contact:

PRESCRIPTION INFORMATION

Needs by Date: **Ship to:** **O Patients home** **O Prescriber 1st order only** **O Prescriber all orders** **O Other**

Drug	Dose	Direction & Quantities	Refills
O Intravenous Immunoglobulin	O 0.4 gm/kg O 1gm/kg O 2gm/kg O _____ grams	Infuse: O IV daily x ____ day(s); repeat every _____ week(s) x _____ cycles O Other: ;	
O Subcutaneous Immunoglobulin		Infuse _____ grams OR _____ mls using _____ sites _____ time(s) per week for	
O Pre-medications:	O Acetaminophen 650mg PO 30 mins prior to infusion O Diphenhydramine 25mg PO 30 mins prior to infusion		
O Other:			
O Other Pre-medications:			

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

Patient Height:_____ in/cm Weight: _____ kg/lbs Allergies: _____ Bun/Creat.:_____

Diagnosis	**ICD-10**	**Diagnosis**	**ICD-10**
Neuromuscular:		**Immune Deficiency:**	
O Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	O CVID w/ Predominant Immunoregulatory T-Cell Disorders	D83.1
O Guillain-Barre Syndrome (GBS)	G61.0	O Combined Immunodeficiency, Unspecified	D81.9
O Multiple Sclerosis (MS)	G35	O SCID with Low T- and B- Cell Numbers	D81.1
O Myasthenia Gravis with (Acute) Exacerbation	G70.01	O SCID with Low or Normal B-Cell Numbers	D81.2
O Myasthenia Gravis (MG)	G70.0	O Other combined Immunodeficiencies	D81.89
O Polymyositis, Organ Involvement Unspecified	M33.20	O Nonfamilial Hypogammaglobulinemia	D80.1
O Dermatopolymyositis & Organ Involvement Unspecified	M33.90	O Selective deficiency of IgA	D80.2
O Stiff Person Syndrome	G25.82	O Selective deficiency of IgM	D80.4
Other:		O Selective deficiency of IgG Subclasses	D80.3
O BMT	Z94.81	O Hereditary Hypogammaglobulinemia	D80.0
O Lymphoid Leukemia	C91.10	O Immunodeficiency with Increased IgM	D80.5
O Multiple Myeloma	C90.0	O Other Common Variable Immunodeficiencies	D83.8
O Plasma Cell Leukemia	C90.1	O Common Variable Immunodeficiency, Unspecified	D83.9
O Thrombocytopenia	D69.6	O Epidermolysis Bullosa	Q81.9
O Prophylactic Immunotherapy	Z41.8	O Kawasaki's syndrome	M30.3
O Other Peripheral Neuropathy	G62.9	O Pemphigoid	L12.0
O Other:		O Pemphigus	L10.9
O IV access [for IVIg patients only]: _____ O Nurse to place PIV prior to therapy		O Systemic lupus erythematosus (SLE)	M32.9

Please Draw: O CBC/diff O CMP O IgG w/ subclasses 1-4 O Quant. Ig O _____ O _____ Frequency:_____

PER Anaphylaxis Protocol:

O Adult – EpiPen 0.3 auto-injector dual pack

O Pediatric - EpiPen 0.15 auto-injector dual pack

Administer intramuscularly in the event of ADR

[May repeat x 1. Order is valid for 1 year]. **Use generic if applicable**

If applicable, flush intravenous access device per Parkway Pharmacy protocol:

Access	**NS**	**Heparin 100 u/ml**
Peripheral	1-3ml before/after use	10u/ml 1-2mls after last NS flush
Midline, central (non-port), PICC	NS 5-10 mls before/after use; 10mls after blood draw	10 u/ml 3-5mls after last NS flush; 5mls after blood draw
Implanted Port	5-10mls before/after use; 20mls after blood draw	100 u/ml 5mls after last NS flush; 5mls after blood draw
Tunneled	5-10mls before/after use; 20mls after blood draw	10 u/ml 3- mls after last NS flush. 5mls after blood draw
Groshong PICC, Midline	5-10mls before/after use; 10mls after blood draw	NO Heparin needed

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Parkway Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: Date

CONFIDENTIALITY NOTICE

Faxed Prescriptions will only be accepted from a prescribing practitioner.