Immune Globulin Therapy Enrollment Form

Date: ________________

Patient Name: ________________

Date of Birth: ________________

Twelvestone Health Partners

FAX referral to: (800)-223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

PREVIOUS IMMUNE GLOBULIN ADMINISTRATION

If YES, please provide the follwing information:

Last IG Infusion Date: ________________

Next Infusion Date: ________________

Previous IG Brand Utilized: ________________

Other Comments: ________________

If NO, please indicate desired location for first dose:

- ☐ Physician's Office
- ☐ TwelveStone Infusion Center
- ☐ TwelveStone Home Infusion
- ☐ Other

Desired Start date: ________________

DIAGNOSIS

Description:	ICD-10 Code

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

- ☐ This signed order Form
- ☐ Patient demographics and Insurance Information
- ☐ History and Physical
- ☐ Clinical Progress Notes, Lab work, (including most recent renal function tests and any other test supporting primary diagnosis)

CLINICAL INFORMATION

(Please attach all clinical information, lab results, and other medical history documents)

Patient Weight____________kg/Lbs Height______________________Inches/CM Allergies: ________________

Line Access: ☐ PIV ☐ PICC (SL DL TL) ☐ PORT (Huber Size - Gauge______Length______) ☐ SUB Q

MEDICATION	DOSE	LAB ORDERS & ADDITIONAL INSTRUCTIONS
Intravaneous ☐ Bivigam® 10% ☐ Gammagard® S/D ☐ Gammagard® Liq. 10% ☐ Gammaked® 10% ☐ Gammaplex® 5% ☐ Gamunex - C® 10% ☐ Privigen® 10% ☐ Carimune® ____% ☐ Other	Order ____________Gms/day x ____________days; OR ____________Gms/Kg divide over_________days ***Frequency***: every ______weeks, or ______one time dose ***Duration***: ☐ 1month ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other	

MEDICATION	DOSE	LAB ORDERS & ADDITIONAL INSTRUCTIONS
Subcutaneous ☐ Gammagard® Liq. 10% ☐ Gammaked® 10% ☐ Gamunex - C® 10% ☐ Hizentra® 10% ☐ Hizentra® 20% ☐ Cuvitru® 20% ☐ Other	Order ___________Gms ***Frequency***: every ______week(s) ***Duration***: ☐ 1month ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other	

PRE-MEDICATION(S)	IV ACCESS FLUSH ORDER
☐ Diphenhydramine 25-50 mg po - 25 mg #2 per dose ☐ Acetaminophen 325 - 650 mg po - 325mg #2 per dose ☐ Methylprednisolone ________mg IV over ______mins ☐ Other: ________________	☐ NaCl 0.9% 5-10ml IV before and after infusion ☐ Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN ☐ Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN ☐ All infusion supplies necessary to administer the medication ☐ Anaphylaxis Kit

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)
By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers.

________________	________________	________________	________________
Dispense as written	Date	Substitution Allowed	Printed Name