Subcutaneous Immune Globulin (SCIG)

Fax Referral To: 877-438-9380

CONTINUUMRX Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis:

_____ Common variable immune deficiency (CVID)
_____ Hypogammaglobulinemia or Select IG Deficiency
_____ Other: _____

Please attach the following: 1. Clinical MD Notes, labs, test supporting primary diagnosis 2. Recent lab results 3. Copy of the patient's Insurance Card 4. Medications List 5. Previous infusion notes/records (if available/ applicable)

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **IMMUNE GLOBULIN (Subcutaneous)**

Preferred Brand ◯ ***Gamunex-C*** ◯ ***Hizentra*** ◯ ***Xembify*** ◯ ***Other:*** _____

☐ ***Administer _____ grams subcutaneously every _____ weeks for _____ cycles***

☐ ***Administer as per the products package insert / protocol***

☐ ***Other Administration instructions:***

_____

_____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date