

HOME INFUSION ORDERS

1. _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. **Medical Information (Please select primary diagnosis and complete ICD10 Code):**

Primary Diagnosis: _____ Common variable immune deficiency (CVID) ICD-10 Code: D83. _____
 _____ Hypogammaglobulinemia or Select IG Deficiency ICD-10 Code: D80. _____
 _____ Other: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

3. **Clinical Information – Please fax with Infusion Order Form:**

- Clinical MD Notes & labs supporting primary diagnosis
- Previous infusion notes/records (if available/applicable)

Patient Weight: _____ lbs. Height: _____ in.

IMMUNE GLOBULIN (Subcutaneous)

4. **Drug Order:**

Administer _____ grams subcutaneously every _____ weeks for _____ cycles

Administer as per the products package insert / protocol

Other Administration instructions: _____

Preferred Brand Gamunex-C Hizentra Xembify Other: _____

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

5. **Physician Signature:** _____ / _____ Date: _____
 Dispense as written Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX 803.794.0404	LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337
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