INTRAMED Plus
infusion services

Subcutaneous Immune Globulin (SCIG)

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 803.999.1754**	**LOCATIONS** **COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**