INTRAMED Plus
infusion services

Subcutaneous Immune Globulin (SCIG)

INFUSION & MEDICAL CENTER

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 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 ❑ Cutaquig ❑ 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**	**INFUSION CENTER LOCATIONS** **COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**

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