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 ❑Cuvitru ❑ 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** BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760

JULY 2023