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 ❑ HyQvia ❑ Xembify

❑ Other: _____

**Anaphylaxis kit to be provided per Intramed Policy:**

Kit includes Epi 1 mg/ml (1), diphenhydramine 50 mg/mL (2), 0.9% NS 500 mL (1) methylprednisolone 125 mg/2 mL (1)

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 #: _____

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| **FAX ALL INFORMATION**<br>**CENTRAL FAX 803.999.1754** | **INFUSION CENTER LOCATIONS**<br>**BERKELEY CHARLESTON COLUMBIA GREENVILLE**<br>**CENTRAL INTAKE PHONE 803.999.1760** |