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 ICD-10 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 our 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 with Credentials: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**