IG Specialist Information

Name:____

Phone:____

Email:____

Patient Information

Patient Name:____

Address:____

City:___________________ State:_______ Zip:_________

DOB:___/___/___/ ☐ Male ☐ Female

Phone:__________________ Mobile:_________________

SSN:___________________ Ht:_________ Wt:_________

Emergency Contact:___________________________________

Relationship:____

Insurance Information *(Attach copy of cards, if available)*

Primary Insurance

Member #:______________________Group#:_________

Policy Holder:__________________Relation:_________

Rx Drug Card:_______________________________________

Secondary Insurance

Member #:______________________Group#:_________

Policy Holder:__________________Relation:_________

Medical Assessment

Height:_____________Weight:____________ ☐ lbs ☐ kg

Advanced Directive? ☐ Yes ☐ No

Kidney or Heart Disease ☐ Yes ☐ No

Ambulatory ☐ Yes ☐ No

Homebound ☐ Yes ☐ No

Diabetic What is current A1C?________________mg/dl

Is Patient currently on any Medication? ☐ Yes ☐ No

If Yes - List or Attach:

____

____

Allergies:

____

____

Diagnosis

	Diagnosis	ICD-10
☐	Chronic Inflammatory Demyelinating Poly Neuropathy (CIPD)	G61.81
☐	Guillain-Barre Syndrome (GBS)	G61.0
☐	Myasthenia Gravis w/ Acute Exacerbation	G70.01
☐	Myasthenia Gravis (MG)	G70
☐	Small Fiber Neuropathy	G62.89
☐	Polymyositis, w/ Organ Involvement Unspecified	M33.90
☐	Dermatopolymyositis w/ Organ Involvement Unspecified	M33.90
☐	Multiple Sclerosis	G35
☐	Stiff Person Syndrome	G25.82
☐	Multifocal Motor Neuropathy (MMN)	G61.82
☐	Sarcoidosis Unspecified	D86
☐	Pemphigus	L10.9
☐	Other Specified Poly Neuropathies	G62.89
☐	Systematic Lupus Erythematosus	M32.9
☐	Other	

Prescription and Orders *(Please check the following)*

Is this the patients first dose? ☐ Yes ☐ No

If no, list product:_________________________________

Date of last infusion:_______Next Dose Due:_______

Administer Ig: ☐ IV ☐ Sub Q

☐ 2 gm/kg Load /1gm/kg Maintenance ☐ 1gm/kg

☐ Other:____

☐ Premedications

☐ Acetaminophen 650mg PO 30 mins prior to infusion

☐ Diphenhydramine 25mg PO 30 mins prior to infusion

☐ Anaphylaxis Kit Per Axiva Protocol

☐ Other:____

Prescribing Physician

Name:____

Address: (please include practice name)

____

____

Phone:___________________Fax:_________________

Specialty:____

License#:_____________________UPIN#:_________

DEA:______________________NPI:________________

By signing below, Physician certifies that the above therapy is medically necessary. Physician agrees to cooperate with Axiva Infusion Services to provide all necessary documentation for submission to patient's third-party payor. Prescriber's signature (sign below)

(Physician attests this is his/her legal signature. NO STAMPS)

Signature:____________________ Date:_________